RUC Recommendations for CPT 2011 Volume I

RUC Meetings October 2009, February 2010 and April 2010

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2011
VOLUME I
TABLE OF CONTENTS

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2010

Hip Arthroscopy

The CPT Editorial Panel created three new codes to report arthroscopic hip reconstructive procedures. Several hundred procedures are expected to be provided to the Medicare population.

29914 Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)

The RUC reviewed the surveyed physician time data from 75 orthopaedic surgeons for 29914 and agreed with the specialty society that they were reflective of service including the additional 17 minutes of pre-service positioning time. This additional time is consistent with the RUC approved pre-service lateral positioning time as established for spinal surgery procedures and therefore determined to be appropriate for this service. The RUC reviewed 29914 and compared it to 29888 *Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction* (Work RVU =14.30). While these services have similar total time 280 minutes and 283 minutes, respectively, the RUC agreed that 29914 should be valued higher because the arthroscopy of the hip is a more intense procedure that requires the physician to cut deeper to reach the joint, while operating in a more confined space compared to other arthroscopy services (knee and shoulder). Further, the RUC compared the surveyed service to 29807 *Arthroscopy, shoulder, surgical; repair of SLAP lesion* (Work RVU =14.67, intra time = 90 minutes). The RUC agreed that this service is similar to the surveyed service with analogous total times (280 minutes and 288 minutes respectively) and comparable work RVUs. Finally, the RUC considered the greater intensity and complexity of 29914 compared with other services and agreed that any work RVU lower than that of 29807 would create a rank order anomaly among the arthroscopy family of codes. **Based on this comparison the RUC recommends that the work of 29914 be crosswalked to 29807, Work RVU of 14.67, a value lower than the survey's 25th percentile.**

29915 Arthroscopy, hip, surgical; acetabuloplasty (ie, treatment of pincer lesion) and 29916 Arthroscopy, hip, surgical; labral repair

The RUC reviewed the surveyed physician time from 75 orthopaedic surgeons for 29915 and 29916 and agreed with the specialty society that they were reflective of the services including the additional 17 minutes of pre-service positioning time. This additional time is consistent with the RUC approved pre-service lateral positioning time as established for spinal surgery procedures and therefore determined to be appropriate for these services. The RUC reviewed 29915 *Arthroscopy, hip, surgical; acetabuloplasty (ie,*

treatment of pincer lesion) and 29916 *Arthroscopy, hip, surgical; labral repair*. The RUC compared these services to 29914 and the other arthroscopy services with RUC-approved times including 29806 *Arthroscopy, shoulder, surgical; capsulorrhaphy* (Work RVU=15.14). The RUC noted that the surveyed codes have less total service time in comparison to 29806, 270 minutes and 298 minutes, respectively. Additionally, the RUC compared these services to 29914 to ensure rank order in the family. The RUC noted that while 29915 and 29916 have less intra-service time, 90 minutes respectively, compared with 100 minutes for 29914, the intensity and complexity is greater and these two services should be valued higher than 29914. The RUC agreed that these two services are more intense than 29914 because of a number of additional elements including: suture anchor placement, additional portals and arthroscopic suture passing and knot tying. **Considering all of these points of comparison, the RUC recommends a Work RVU of 15.00 for both 29915 and 29916, a value lower than the surveys' 25th percentile.**

In addition, the RUC discussed at length the issue of high IWPUTs for these services and agree that the recommended times accurately reflect reasonable IWPUTs. With the recommended work RVUs, 29914 has an IWPUT of .094. This value is comparable to the IWPUTs of the other RUC-approved reference services (29888= .089 and 29807= .097). The RUC reviewed the IWPUTs for the more intense procedures 29915 and 299146 (IWPUT = .108) and agreed that they were reasonable as these services are the most intense arthroscopic procedures currently being performed by physicians.

Practice Expense: The specialty recommended and the RUC recommends standard 090 day global practice expense inputs, for these are provided only in the facility setting.

New Technology: As the technology to perform these services is new and to ensure that the utilization estimates provided by the specialty are accurate, **the RUC recommended that 29914, 29915 and 29916 be added to the New Technology/Service List.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
29863		Arthroscopy, hip, surgical; with synovectomy	090	11.17 (No Change)
•29914	X1	with femoroplasty (ie, treatment of cam lesion)	090	14.67

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●29915	X2	with acetabuloplasty (ie, treatment of pincer lesion) (Do not report 29914, 29915 in conjunction with 29862, 29863)	090	15.00
●29916	X3	with labral repair (Do not report 29916 for labral repair secondary to acetabuloplasty or in conjunction with 29862, 29863)	090	15.00

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:29914 Tracking Number X1 Specialty Society Recommended RVU: **15.00**
Global Period: 090 RUC Recommended RVU: **14.67**

CPT Descriptor: Arthroscopy, hip, surgical; femoroplasty (ie, treatment of cam lesion)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57 year old man presents with a five month history of increasing left groin pain. The pain is worse with sitting and arising from a seated position. Physical examination reveals a loss of hip internal rotation. X-rays show a cam lesion at the femoral head-neck junction. An intra-articular injection of corticosteroids provides only temporary relief of the symptoms. A 3-D CT scan shows the cam lesion. Surgery is recommended to reshape the femoral head and neck junction.

Percentage of Survey Respondents who found Vignette to be Typical: 68%

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 66% , Kept overnight (less than 24 hours) 34% , 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 39%

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

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

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

Description of Pre-Service Work: • Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Review and update H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review and update informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with positioning of patient on a fracture table in the lateral position.
- Pad bony prominences and pelvic post.
- Assess access to the joint with flouroscope.
- Assess position of the extremities and head, adjust as needed
- 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: The patient is brought to the operating room and placed on a traction table. Distraction of the joint is verified with fluoroscopy. The hip is then prepped and draped in a sterile fashion. Arthroscopic portals are established with standard technique using a long spinal needle, flexible guidewire, and a cannulated obturator and sheath.

The scope sheath is inserted through an anterolateral portal. An anterior portal is then established under direct arthroscopic and C-arm visualization . A capsulotomy is performed to enable visualization in the peripheral compartment.
Additional portals are created for work in the peripheral compartment. The cam lesion of the femoral head / neck junction is visualized, and the area of abnormal bone is outlined with a radiofrequency device using arthroscopic and fluoroscopic guidance to assure adequate bone removal. The cam lesion is then removed using a powered burr and shaver with fluoroscopic and direct visualization. The capsulotomy is then repaired. The peripheral compartment is distended with local anesthetic, the portals are closed with nylon sutures, and a sterile dressing is applied. The patient is transferred to the recovery room.

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

- Application of a dressing and sling.
- 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).
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge; complete medication reconcillation
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
  Removal of sling/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order physical therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions; complete medication reconcillation
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010		
Presenter(s):	William Creevy, MD; Louis McIntyre, MD		
Specialty(s):	Orthopaedic Surgery		
CPT Code:	29914		
Sample Size:	500	**Resp N:** 75	**Response:** 15.0 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	10.00	**22.00**	45.00	320.00
Survey RVW:	10.00	15.00	**17.50**	20.00	24.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**20.00**		
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:	**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):	**10.00**	99231x **0.50** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 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:	29914	**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:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
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):	**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):	**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**

Modifier -51 Exempt Status

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

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
27709	090	17.48	**RUC Time**

CPT Descriptor Osteotomy; tibia and fibula

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36819	090	14.47	**RUC Time**	11,550

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
33249	090	15.17	**RUC Time**	5,031

CPT Descriptor 2 Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator

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:** 24.0 %

TIME ESTIMATES (Median)	**CPT Code: 29914**	**Key Reference CPT Code:** 27709	**Source of Time** RUC Time
Median Pre-Service Time	63.00	68.00	
Median Intra-Service Time	100.00	108.00	
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	40.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	78.0	78.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**280.00**	**347.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.13	3.41
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.31	3.65
Urgency of medical decision making	2.81	2.76

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.47
Physical effort required	4.44	4.18

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.06	3.82
Outcome depends on the skill and judgment of physician	4.81	4.35
Estimated risk of malpractice suit with poor outcome	3.81	3.59

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	3.88
Intra-Service intensity/complexity	4.69	4.35
Post-Service intensity/complexity	3.38	3.59

Additional Rationale

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

29914, Arthroscopy, hip, surgical; femoroplasty (ie, treatment of cam lesion) was approved by the CPT Editorial Panel a a new category I code at the February 2010 meeting. The AAOS then conducted a RUC random-sample survey to access the estimated work, time and intensity measures for 29914. We received 75 complete, non-conflicted, responses to the survey. The AAOS then convened an expert consensus panel to review the survey data.

The AAOS is recommending a work RVU of 15.00 for 29914. 15.00 is the 25th percentile RVU from our survey. We choose the pre-service package 3, straightforward patient/difficult procedure which provides 33 minutes pre-service evaluation time, 3 minutes pre-service positioning time, and 15 minutes pre-service scrub, dress and wait time. However, we adjusted the positioning time by adding 17 minutes for lateral positioning for a total of 20 minutes positioning time. This is consistent with the RUC approved pre-service lateral positioning time as established for spinal surgery procedures. We also subtracted 5 minutes of scrub, dress and wait time from pre-service package 3 as our median survey estimated SDW time was 10 minutes and not 15. Thus, we changed the pre-service SDW time to match our median survey response. Our median intra-service time was 100 minutes, with 20 minutes immediate post-service. Our surveyees indicated a majority of patients have the procedure performed in a facility and are discharged the same day as surgery. Thus, we've recommended a half-day discharge visit equal to 0.5-99238. Our surveyees indicated a typical patient will be seen in the office for post-operative visits 4 times total. We are recommending 2-99213 visits and 2-99212 visits. This is consistent with the reference service code, 27709, Osteotomy; tibia and fibula. The median work RVU from our survey was 17.50, which is nearly identical to the work RVU of our reference code at 17.48.

We are recommending the 25th percentile work RVU of 15.00 with a total time of 280 minutes. We felt the median work RVU of 17.50 resulted in an IWPUT of 0.120 that was unreasonably high. The IWPUT of 29914 with a work RVU of 15.00 is 0.97, which is still higher than our reference code. However, the higher IWPUT is borne out by looking at the intensity and complexity measures above. Our surveyees indicated that 10 of the 11 categories had a higher intensity for 29914 than 27709. The average percentage difference in work intensity measures (on a scale of 1-5) between 29914 and 27707 was 6.91%, meaning our survey indicated 29914 is more complex and intense than 27707. The difference in intensity for question 10, which is in regards to the intensity of skin-to-skin time, for intra-time was 0.34 (7.25%).

We believe the 25th percentile value and the recommended times are appropriate relative to CPT code 27709 and recommend a work RVU of 15.00. This value is also appropriate relative to the other two codes surveyed, 29915 and 29916 for which we're recommending a slightly higher work RVU of 15.30 which is appropriate as X5 and X6 are higher intensity, riskier procedures.

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

low was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted ode is reviewed) 29999,Unlisted procedure, arthroscopy

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

Specialty orthopaedics How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2,000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Consensus expert panel estimate

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 200
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Consensus expert panel estimate (please note, the typical patient is not Medicare age and we anticipate a low percentage of the total national frequency to be for Medicare patients (no more than 10% of the national total)

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

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

If no, please select another crosswalk and provide a brief rationale. 29866 - same RVUs

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:29915 Tracking Number X2 Specialty Society Recommended RVU: **15.30**
Global Period: 090 RUC Recommended RVU: **15.00**

CPT Descriptor: Arthroscopy, hip, surgical; acetabuloplasty (ie, treatment of pincer lesion)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old man presents with a four month history of left hip pain and popping. The pain is worse with sitting and arising from a seated position. Physical exam reveals loss of hip motion. X-rays show a "cross-over" sign of the acetabulum. Corticosteroid injection in the hip gives only temporary relief. A 3-D CT scan shows bony acetabular deformity. Surgery is recommended to remove a portion of the bony acetabular rim and eliminate the abnormal contact between the rim and the femoral neck

Percentage of Survey Respondents who found Vignette to be Typical: 89%

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 66% , Kept overnight (less than 24 hours) 32% , 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 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? 0%

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

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

Description of Pre-Service Work: • Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Review and update H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review and update informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with positioning of patient on a fracture table in the lateral position.
- Pad bony prominences and pelvic post.
- Assess access to the joint with flouroscope.
- Assess position of the extremities and head, adjust as needed
- 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: The patient is brought to the operating room and placed on a traction table. Distraction of the joint is verified with fluoroscopy. The hip is then prepped and draped in a sterile fashion. Arthroscopic portals are established with standard technique using a long spinal needle, flexible guidewire, and a cannulated obturator and sheath. The scope sheath is inserted through an anterolateral portal. An anterior portal is then established under direct arthroscopic

and C-arm visualization. A capsulotomy is performed to facilitate resection in the peripheral compartment.The acetabular rim is then resected with a motorized burr in both the central and peripheral compartments of the hip. Adequate resection is confirmed both arthroscopically and with fluoroscopy. Any labral detachment that has been performed in order to access the bony acetabular deformity is then re-attached using suture anchors. The capsulotomy is repaired. The peripheral compartment is distended with local anesthetic. The portals are closed with nylon sutures and a sterile dressing is applie The patient is transferred to the recovery room.

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

- Application of a dressing and sling.
- 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).
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge; complete medication reconcillation
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of sling/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order physical therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions; complete medication reconcillation
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	William Creevy, MD; Louis McIntyre, MD				
Specialty(s):	Orthopaedic Surgery				
CPT Code:	29915				
Sample Size:	500	**Resp N:**	75	**Response:** 15.0 %	
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	4.00	**12.00**	30.00	160.00
Survey RVW:	10.00	15.30	**17.50**	20.00	24.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	45.00	90.00	**90.00**	120.00	180.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**10.00**	99231x **0.50** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 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:	29915	**Recommended Physician Work RVU: 15.30**		
		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:		**10.00**	**15.00**	**-5.00**
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):	**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**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure 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
29827	090	15.59	**RUC Time**

CPT Descriptor Arthroscopy, shoulder, surgical; with rotator cuff repair

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
33249	090	15.17	**RUC Time**	5,031

CPT Descriptor 1 Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19303	090	15.85	**RUC Time**	20,714

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: 20 **% of respondents:** 26.6 %

TIME ESTIMATES (Median)	**CPT Code: 29915**	**Key Reference CPT Code:** 29827	**Source of Time** RUC Time
Median Pre-Service Time	63.00	75.00	
Median Intra-Service Time	90.00	120.00	
Median Immediate Post-service Time	20.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	80.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**270.00**	**334.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.85	3.35
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.10	3.30
Urgency of medical decision making	2.40	2.50

Technical Skill/Physical Effort (Mean)

Technical skill required	4.90	4.40
Physical effort required	4.55	4.11

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.55	3.30
Outcome depends on the skill and judgment of physician	4.60	4.30
Estimated risk of malpractice suit with poor outcome	3.30	3.15

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.45	4.15
Intra-Service intensity/complexity	3.00	3.02
Post-Service intensity/complexity	3.00	3.05

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.*

29915, Arthroscopy, hip, surgical; acetabuloplasty (ie, treatment of pincer lesion) was approved by the CPT Editorial Panel as a new category I code at the February 2010 meeting. The AAOS then conducted a RUC random-sample survey to access the estimated work, time and intensity measures for 29915. We received 75 complete, non-conflicted, responses to the survey. The AAOS then convened an expert consensus panel to review the survey data.

The AAOS is recommending a work RVU of 15.30 for 29915. 15.30 is the 25th percentile RVU from our survey. We choose the pre-service package 3, straightforward patient/difficult procedure which provides 33 minutes pre-service evaluation time, 3 minutes pre-service positioning time, and 15 minutes pre-service scrub, dress and wait time. However, we adjusted the positioning time by adding 17 minutes for lateral positioning for a total of 20 minutes positioning time. This is consistent with the RUC approved pre-service lateral positioning time as established for spinal surgery procedures. We also subtracted 5 minutes of scrub, dress and wait time from pre-service package 3 as our median survey estimated SDW time was 10 minutes and not 15. Thus, we changed the pre-service SDW time to match our median survey response. Our median intra-service time was 90 minutes, with 20 minutes immediate post-service. Our surveyees indicated a majority of patients have the procedure performed in a facility and are discharged the same day as surgery. Thus, we've recommended a half-day discharge visit equal to 0.5-99238. Our surveyees indicated a typical patient will be seen in the office for post-operative visits 4 times total. We are recommending 2-99213 visits and 2-99212 visits. This is fewer post-service office visits than our reference service code, 29827, Arthroscopy, shoulder, surgical; with rotator cuff repair.

We are recommending the 25th percentile work RVU of 15.30 with a total time of 270 minutes. We felt the median work RVU of 17.50 resulted in an IWPUT of 0.133 that was unreasonably high. The IWPUT of 29914 with a work RVU of 15.30 is 0.112, which is still higher than our reference code. However, the higher IWPUT is borne out by looking at the intensity and complexity measures above. Our surveyees indicated that 9 of the 11 categories had a higher intensity for 29915 than 29827. The average percentage difference in work intensity and complexity measures was 7.23% meaning that on average, our surveyees felt that 29915 was a more complex and intense procedure than 29827. The difference in intensity for question 10, which is for intra-time was 6.74%.

We believe the 25th percentile work value of 15.30 and the recommended times totaling 270 minutes are appropriate relative to CPT code 29827 with a work RVU of 15.59 and total time of 334 minutes and recommend a work RVU of 15.30. The total time is slightly more for 29827 than for 29915 but the intensity of 29915 is greater than 29827 and therefore a total value of 15.30 is justified. This value is also appropriate relative to the other two codes surveyed, 29914 and 29916. Our recommendation is for 15 and 16 to have the same values as the surveys indicated they have the same times. 15 and 16 have very slightly higher recommended work RVUs than X4, and we believe this appropriate as 15 and 16 are higher intensity, riskier procedures than 14.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 29999,Unlisted procedure, arthroscopy

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

Specialty orthopaedics How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Consensus expert panel estimate

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Consensus expert panel estimate (please note, the typical patient is not Medicare age and we anticipate a low percentage of the total national frequency to be for Medicare patients (no more than 10% of the national total)

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. 29806 - closer RVU

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:29916 Tracking Number X3 Specialty Society Recommended RVU: **15.30**
Global Period: 090 RUC Recommended RVU: **15.00**

CPT Descriptor: Arthroscopy, hip, surgical; labral repair

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A twenty year old presents with a two month history of right groin pain and popping following a softball injury. Physical examination reveals pain with flexion, adduction and internal rotation. Motion is normal. A steroid injection of the hip affords only temporary relief. MRI arthrogram shows a tear of the acetabular labrum. Surgical treatment is recommended to repair the torn labrum.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Percent of survey respondents who stated they perform the procedure; In the hospital 75% , In the ASC 25%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 71% , Kept overnight (less than 24 hours) 29% , 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 44%

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

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

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

Description of Pre-Service Work: • Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Review and update H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review and update informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with positioning of patient on a fracture table in the lateral position.
- Pad bony prominences and pelvic post.
- Assess access to the joint with flouroscope.
- Assess position of the extremities and head, adjust as needed
- 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: The patient is brought to the operating room and placed on a special traction table in the supine position. Distraction of the joint is verified with fluoroscopy. Arthroscopic portals are established with standard techniques with a long spinal needle, flexible guidewire, and a cannulated obturator and sheath. The scope sheath is inserted through an anterolateral portal. The anterior portal is then established under direct arthroscopic and C-arm visualization.The labrum is closely examined and probed to determine tears, and to determine the stability of the labrum.

Soft tissues are elevated from the acetabulum to prepare for labral repair. A drill guide is used through an accessory portal to drill holes in the acetabular rim, and suture anchors are placed. The sutures are then retrieved thru the labrum in a horizontal mattress stitch using suture retrievers and graspers. The sutures are then tied on the extraariticular side of the labrum to avoid contact with the femoral head. After the repair is completed the hip capsule is repaired to minimize the isk of post-operative instability. This is done by using suture passers and retrievers brought in through the various portals, and sutures are passed thru the capsular tissues and tied with arthroscopic knot tying techniques. After the procedure is completed, the instruments are backed out of the central compartment, and the traction is released. The joint is distended with local anesthetic, the portals are closed with nylon sutures, sterile dressings are applied, and the patient is transferred to the recovery room.

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

- Application of a dressing and sling.
- 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).
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge; complete medication reconcillation
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office

- Examine and talk with patient
  Answer patient/family questions
- Removal of sling/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order physical therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions; complete medication reconcillation
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010		
Presenter(s):	William Creevy, MD; Louis McIntyre, MD		
Specialty(s):	Orthopaedic Surgery		
CPT Code:	29916		
Sample Size:	500	**Resp N:** 75	**Response:** 15.0 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	4.00	**10.00**	30.00	320.00
Survey RVW:	11.00	16.00	**17.00**	20.00	25.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	50.00	80.00	**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):	**10.00**	99231x **0.50** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 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:	29916	**Recommended Physician Work RVU: 15.30**		
		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:		**10.00**	**15.00**	**-5.00**
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):	**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**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure 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
29827	090	15.59	**RUC Time**

CPT Descriptor Arthroscopy, shoulder, surgical; with rotator cuff repair

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
33249	090	15.17	**RUC Time**	5,031

CPT Descriptor 1 Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19303	090	15.85	**RUC Time**	20,714

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: 28 **% of respondents:** 37.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 29916**	**Key Reference CPT Code: 29827**	**Source of Time RUC Time**
Median Pre-Service Time	63.00	75.00	
Median Intra-Service Time	90.00	120.00	
Median Immediate Post-service Time	20.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	78.0	80.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**270.00**	**334.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.27	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.46	3.84
Urgency of medical decision making	3.00	2.96

Technical Skill/Physical Effort (Mean)

Technical skill required	4.77	4.36
Physical effort required	4.38	3.96

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.77	3.64
Outcome depends on the skill and judgment of physician	4.69	4.56
Estimated risk of malpractice suit with poor outcome	3.54	3.44

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.12	3.68
Intra-Service intensity/complexity	4.58	4.08
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.*

29916, Arthroscopy, hip, surgical; labral repair was approved by the CPT Editorial Panel as a new category I code at the February 2010 meeting. The AAOS then conducted a RUC random-sample survey to access the estimated work, time and intensity measures for 29916. We received 75 complete, non-conflicted, responses to the survey. The AAOS then convened an expert consensus panel to review the survey data.

The AAOS is recommending a work RVU of 15.30 for 29916. 15.30 is less than the 25th percentile RVU from our survey which was 16.00. We choose the pre-service package 3, straightforward patient/difficult procedure which provides 33 minutes pre-service evaluation time, 3 minutes pre-service positioning time, and 15 minutes pre-service scrub, dress and wait time. However, we adjusted the positioning time by adding 17 minutes for lateral positioning for a total of 20 minutes positioning time. This is consistent with the RUC approved pre-service lateral positioning time as established for spinal urgery procedures. We also subtracted 5 minutes of scrub, dress and wait time from pre-service package 3 as our median survey estimated SDW time was 10 minutes and not 15. Thus, we changed the pre-service SDW time to match our median survey response. Our median intra-service time was 90 minutes, with 20 minutes immediate post-service. Our surveyees indicated a majority of patients have the procedure performed in a facility and are discharged the same day as surgery. Thus, we've recommended a half-day discharge visit equal to 0.5-99238. Our surveyees indicated a typical patient will be seen in the office for post-operative visits 4 times total. We are recommending 2-99213 visits and 2-99212 visits. This is fewer post-service office visits than our reference service code, 29827, Arthroscopy, shoulder, surgical; with rotator cuff repair.

We are recommending a value of 15.30, below the 25th percentile work RVU of 16.00 with a total time of 270 minutes. We felt the median work RVU of 17.00 resulted in an IWPUT of 0.128 that was unreasonably high. The IWPUT of 29916 with a work RVU of 15.30 is 0.112, which is still higher than our reference code. However, the higher IWPUT is borne out by looking at the intensity and complexity measures above. Our surveyees indicated that 11 of the 11 categories had a higher intensity for 29916 than 29827. The average percentage difference in work intensity and complexity measures was 7.53% meaning that on average, our surveyees felt that 29916 was a more complex and intense procedure than 29827. The difference in intensity for question 10, which is for intra-time was 10.92%.

We believe the 25th percentile work value of 15.30 and the recommended times totaling 270 minutes are appropriate relative to CPT code 29827 with a work RVU of 15.59 and total time of 334 minutes and recommend a work RVU of 15.30. The total time is slightly more for 29827 than for 29916 but the intensity of 29916 is greater than 29827 and therefore a total value of 15.30 is justified. This value is also appropriate relative to the other two codes surveyed, 29914 and 29916. Our recommendation is for 15 and 16 to have the same values as the surveys indicated they have the same times. 15 and 16 have very slightly higher recommended work RVUs than X4, and we believe this appropriate as 15 and 16 are higher intensity, riskier procedures than 14.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 29999,Unlisted procedure, arthroscopy

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

Specialty orthopaedics How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Consensus expert panel estimate

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Consensus expert panel estimate (please note, the typical patient is not Medicare age and we anticipate a low percentage of the total national frequency to be for Medicare patients (no more than 10% of the national total)

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. 29806 - closer RVU

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

HIP ARTHROSCOPY & COMPARISON CODES

					Total	Preoperative			Intra	Hospital		Office				
	CPT	DESC	IWPUT	RVW	Time	EVAL	POSIT	SDW	MED	P-SD	38	15	14	13	12	11
RUC	29860	Hip diagnostic+/- synovial biopsy (sep. procedure)	0.053	9.00	244	75			70	30				3		
RUC	29861	Hip removal of loose body or foreign body	0.060	10.10	254	75			80	30				3		
RUC	29862	Hip debridement/shaving (chondroplasty)	0.049	11.17	297	75			100	30				4		
RUC	29863	Hip synovectomy	0.049	11.17	297	75			100	30				4		
SVY	298X4	Hip femoroplasty	0.094	14.67	280	33	20	10	100	20	0.5			2	2	
SVY	298X5	Hip acetabuloplasty	0.108	15.00	270	33	20	10	90	20	0.5			2	2	
SVY	298X6	Hip labral repair	0.108	15.00	270	33	20	10	90	20	0.5			2	2	
RUC	29888	Knee ACL	0.092	14.30	283	33	15	15	98	25	0.5			2	2	
RUC	29866	Knee osteochondral autograft(s)	0.087	14.67	308	45	15	15	100	20	0.5			2	3	
RUC	29828	Arthroscopy shoulder, biceps tenodesis	0.104	13.16	262	40	15	15	75	20	0.5			2	2	
RUC	29807	Arthroscopy shoulder, SLAP repair	0.097	14.67	288	55			90	30	0.5			2	3	
RUC	29806	Arthroscopy shoulder, capsulorraphy	0.092	15.14	298	55			100	30	0.5			2	3	
RUC	29827	Arthroscopy shoulder, rotator cuff repair	0.083	15.59	334	75			120	40	0.5				5	

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

CPT Long Descriptor:

29914 Arthroscopy, hip, surgical; femoroplasty (ie, treatment of cam lesion)

(Do not report 298XX4, 298XX5 with 29860, 29862, 29863)

29915 ***Arthroscopy, hip, surgical*** **acetabuloplasty; (ie, treatment of pincer lesion)**

(Do not report 298XX4, 298XX5 with 29860, 29862, 29863)

29916 Arthroscopy, hip, surgical; labral repair

(Do not report 298XX6 for labral repair secondary to acetabuloplasty or with 29860, 29862, 29863)

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

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

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

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

Intra-Service Clinical Labor Activities:

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

The standard 12 minutes has been applied for the inpatient procedure for half-day discharge management services from the facility.

Post-Service Clinical Labor Activities:

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

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			29914		29915	
2	**Meeting Date: April 2010**			Arthroscopy, hip, surgical; femoroplasty (ie, treatment of a cam lesion)		Arthroscopy, hip, surgical; acetabulooplasty (ie, treatment of a pincer lesion)	
3	LOCATION	Code	Staff Type	Office	Facility	Office	Facility
4	GLOBAL PERIOD			090	090	090	090
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	192	N/A	192
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	60	N/A	60
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	6	N/A	6
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	126	N/A	126
9	PRE-SERVICE						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7
17	**End: When patient enters office/facility for surgery/procedure**						
18	SERVICE PERIOD						
39	Discharge day management 99238 --12 minutes	L037D	RN/LPN/MTA		6		6
41	**End: Patient leaves office/FACILITY**						
42	POST-SERVICE Period						
43	**Start: Patient leaves office/facility**						
44	Conduct phone calls/call in prescriptions						
46	*List Number and Level of Office Visits*						
47	99211 16 minutes		16				
48	99212 27 minutes	L037D	27		2		2
49	99213 36 minutes	L037D	36		2		2
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	Other						
54	*Total Office Visit Time*				126		126
55	Other Activity (please specify)						
56	**End: with last office visit before end of global period**						
57	MEDICAL SUPPLIES	CMS Code	Unit				
58	pack, minimum multi-specialty visit	SA048	pack		4		4
59	pack, post-op incision care (suture)	SA054	kit		1		1
60							
61							
62	Equipment	CMS Code	Utilization Percentage				
63	table, power	EF031	100%		126		126
64	light, exam	EQ168	100%		126		126

	A	B	C	H	I
1	AMA/Specialty Society RVS Update Committee Recommendation			29916	
2	**Meeting Date: April 2010**			Arthroscopy, hip, surgical; labral repair	
3	LOCATION	Code	Staff Type	Office	Facility
4	GLOBAL PERIOD			090	090
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	192
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	60
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	6
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	126
9	PRE-SERVICE				
10	**Start: Following visit when decision for surgery or procedure made**				
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7
17	**End: When patient enters office/facility for surgery/procedure**				
18	SERVICE PERIOD				
39	Discharge day management 99238 --12 minutes	L037D	RN/LPN/MTA		6
41	**End: Patient leaves office/FACILITY**				
42	POST SERVICE Period				
43	**Start: Patient leaves office/facility**				
44	Conduct phone calls/call in prescriptions				
46	*List Number and Level of Office Visits*				
47	99211 16 minutes		16		
48	99212 27 minutes	L037D	27		2
49	99213 36 minutes	L037D	36		2
50	99214 53 minutes		53		
51	99215 63 minutes		63		
52	Other				
54	*Total Office Visit Time*				126
55	Other Activity (please specify)				
56	**End: with last office visit before end of global period**				
57	MEDICAL SUPPLIES	CMS Code	Unit		
58	pack, minimum multi-specialty visit	SA048	pack		4
59	pack, post-op incision care (suture)	SA054	kit		1
60					
61					
62	Equipment	CMS Code	Utilization Percentage		
63	table, power	EF031	100%		126
64	light, exam	EQ168	100%		126

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2010

Nasal/Sinus Endoscopy with Balloon Dilation

In October 2009, the CPT Editorial Panel modified introductory language to the nasal/sinus endoscopy section and added three new CPT codes to report balloon dilation when performed alone for a given sinus ostium. The use of balloon dilation alone is now more frequently performed for maxillary, frontal, and sphenoid sinuses.

31295

The RUC reviewed specialty survey data from 33 otolaryngologists who had experience with these three new procedures. The RUC reviewed new code 31295 *Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa,* which describes the endoscopic treatment of acute and chronic sinusitis by dilation of the maxillary sinus ostium. Upon review of the physician time survey results, the RUC recommended the pre-time evaluation and scrub, dress, wait time be reduced from pre-time package 3 so as not to exceed the survey median time for these pre-service components. All other physician time components, intra-service and post service, were understood to be typical. The specialty survey data indicated in a median work RVU of 5.00, which the specialty and the RUC agreed overstated the total physician work relative to the key reference code 31254 *Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)* (000 day global, Work RVU = 4.64) and 31256 *Nasal/sinus endoscopy, surgical, with maxillary antrostomy;* (000 day global, Work RVU = 3.29), which is a similar maxillary endoscopy procedure that is more extensive, including tissue excision.

31

The RUC also reviewed the physician work of 31233 *Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture* (000 day global, Work RVU = 2.18) and estimated that the physician work for 31295 is approximately 25% more total work than 31233, or 2.70 work RVUs [2.18 x 125% = 2.70]. This recommendation takes into account the increased complexity and additional pre and post work required for 31295 which is a facility-based procedure compared with 31233 which is primarily performed in an office setting.

The RUC reviewed similarly valued services across specialties to validate its recommendation, these 000 day global codes were; 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU = 2.70, MPC code, 20 minutes intra-service time), 49452

Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report (work RVU = 2.86, 20 minutes intra-service time), and 36555 *Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age* (work RVU = 2.68, 20 minutes of intra-service time). The work RVU recommendation of is below the 25th percentile specialty survey results and places the work of 31295 correctly between 31233 (Work RVU = 2.18) and 31256 (Work RVU = 3.29). **The RUC recommends a relative work value of 2.70 for CPT Code 31295.**

31296

The RUC reviewed the survey data from 35 otolaryngologists who were familiar with 31296 *Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)*, that describes the endoscopic treatment of acute and chronic sinusitis by dilation of the frontal sinus ostium. Upon review of the physician time survey results the RUC recommended the pre-time evaluation and scrub, dress, wait time be reduced from pre-time package 3 so as not to exceed the survey median time for these pre-service components. All other physician time components, intra-service and post service, were understood to be typical. The specialty survey data indicated in a median work RVU of 7.00, which the specialty and the RUC agreed overstated the total physician work relative to the key reference code 31255 *Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)* (000 day global, Work RVU = 6.95).

32

To place the total work of 31296 relative to other sinus surgical procedures, the RUC determined that the total work of 31296 would be similar to the total work effort of 31256 *Nasal/sinus endoscopy, surgical, with maxillary antrostomy* (work RVU = 3.29, 45 minutes/Harvard). Although the intra-time for 31256 is greater than 31296, the expertise required and complexity is greater for 31296 (ie, passing the guide wire through the labyrinth of the frontal recess, between lamina (bone over orbit) and cribriform, near the anterior ethmoidal artery).

The RUC reviewed similarly valued services across specialties to validate its recommendation, these 000 day global codes were; 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU = 3.36, 30 minutes intra-service time), 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU = 3.30, 30 minutes intra-service time), and 52000 *Cystourethroscopy (separate procedure)* (work RVU = 2.23, 15 minutes of intra-service time).

The RUC considered that the recommendation for 31296 should be greater than the recommendations for 31295 (RVW=2.70) and 31297 (RVW=2.64); and is approximately three times more work than 31231 *Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)* (work RVU = 1.10, 10 minutes intra-service time). The work value of 3.29 for 31296 provides proper rank order for physician work and intensity within this group of services and across specialties. Therefore, a work RVU of 3.29 is recommended for

31296. This value is below the 25th percentile surveyed work RVU of 5.10 and appropriately places 31296 relative to the other sinus balloon endoscopy procedures, the identical value of 31256. **The RUC recommends a relative work value of 3.29 for CPT Code 31296.**

31297

The RUC reviewed the survey data from 32 otolaryngologists who were familiar with 31297 *Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation),* which describes the endoscopic treatment of acute and chronic sinusitis by dilation of the sphenoid. Upon review of the physician time survey results the RUC recommended the pre-time evaluation and scrub, dress, wait time be reduced from pre-time package 3 so as not to exceed the survey median time for these pre-service components. All other physician time components, intra-service and post service, were understood to be typical. The specialty survey data indicated in a median work RVU of 6.05, which the specialty and the RUC agreed overstates the total physician work relative to the key reference code 31255 *Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)* (000 day global, Work RVU = 6.95). The RUC agreed that the total physician work for 31297 should be crosswalked to 31235 *Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)*, (000 global, Work RVU = 2.64) which requires similar time and intensity to perform. The RUC agreed that CPT code 31297 should have the same work value as 31235, as it appropriately places 31297 slightly less than 31295, and less than 31287 *Nasal/sinus endoscopy, surgical, with sphenoidotomy,* (000 day global, Work RVU = 3.91). The work value of 2.64 for 31297 would provide proper rank order for physician work and intensity within this group of services and across specialties.

33

The RUC reviewed similarly valued services across specialties to validate its recommendation, these 000 day global codes were; 43220 *Esophagoscopy, rigid or flexible; with balloon dilation (less than 30 mm diameter)* (work RVU = 2.10, 22 minutes intra-service time), 52281 *Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female* (work RVU = 2.80, 33 minutes intra-service time/Harvard), and 52000 *Cystourethroscopy (separate procedure)* (work RVU = 2.23, 15 minutes of intra-service time).

Practice Expense: The RUC reviewed the direct practice expense inputs for CPT codes 31295, 31296, and 31297 and made minor adjustments to reflect the typical patient service in the facility and non-facility settings.

New Technology: The RUC considers CPT codes 31295, 31296, and 31297 be placed on the RUC's new technology listing.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
A surgical sinus endoscopy includes a sinusotomy (when appropriate) and diagnostic endoscopy. Codes 31295-31297 describe dilation of sinus ostia by displacement of tissue, any method, and include fluoroscopy if performed. Codes 31233-31297 are used to report unilateral procedures unless otherwise specified. *The codes 31231-31235 for ...*				
31231		Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	000	1.10 (No Change)
31233		Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture) (Do not report 31233 in conjunction with 31295 when performed on the same sinus)	000	2.18 (No Change)
31235		Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium) (Do not report 31235 in conjunction with 31297 when performed on the same sinus)	000	2.64 (No Change)
31237		Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	000	2.98 (No Change)
31238		with control of nasal hemorrhage	000	3.26 (No Change)
31256	I1	Nasal/sinus endoscopy, surgical with maxillary antrostomy;	000	3.29 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
31267	I2	with removal of tissue from maxillary sinus (Do not report 31256, 31267 in conjunction with 31295 when performed on the same sinus)	000	5.45 (No Change)
31276	I3	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus (Do not report 31276 in conjunction with 31296 when performed on the same sinus)	000	8.84 (No Change)
31287	I4	Nasal/sinus endoscopy, surgical with sphenoidotomy;	000	3.91 (No Change)
31288	I5	with removal of tissue from the sphenoid sinus (Do not report 31287, 31288 in conjunction with 31297 when performed on the same sinus)	000	4.57 (No Change)
●31295	I6	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa (Do not report 31295 in conjunction with 31233, 31256, 31267 when performed on the same sinus)	000	2.70
●31296	I7	with dilation of frontal sinus ostium (eg, balloon dilation) (Do not report 31296 in conjunction with 31276 when performed on the same sinus)	000	3.29
●31297	I8	with dilation of sphenoid sinus ostium (eg, balloon dilation) (Do not report 31297 in conjunction with 31235, 31287, 31288 when performed on the same sinus)	000	2.64

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:31295 Tracking Number I6 Specialty Society Recommended RVU: **2.70**
Global Period: 000 RUC Recommended RVU: **2.70**

CPT Descriptor: Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old patient who has failed medical management presents with chronic maxillary sinusitis, characterized by maxillary discomfort, purulent drainage from the maxillary ostium, and/or maxillary outflow (infundibulum) obstruction, is considered a candidate for balloon dilation of the ostium.

Percentage of Survey Respondents who found Vignette to be Typical: 76%

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

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

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

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

Moderate Sedation

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

Is moderate 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. 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. Mark sinus side for procedure. Obtain informed consent. 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, endoscopy and video equipment, and anesthesia lines. Ensure that radiographic images are available in the OR. Monitor/assist with prepping and draping. Scrub and gown. Administer intranasal topical anesthetic/vasoconstrictive medication. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: After induction of anesthesia, an intranasal anesthetic/vasoconstrictive agent is injected Under endoscopic visualization a guide-wire is introduced into the maxillary ostium via either a transnasal or sublabi transmaxillary (puncture) approach. A deflated balloon catheter is threaded over the guide wire and introduced into the maxillary ostium. Positioning of both the guide-wire and the balloon are confirmed endoscopically (and perhaps with transillumination or via fluoroscopy) during the course of the placement of each. The balloon is then inflated resulting in

dilation of the natural ostium of the sinus, displacing bone and mucosa. After dilation the balloon is deflated and removed. In some cases, a separate catheter can be introduced over the guide-wire for irrigation of the sinus.

Description of Post-Service Work: Monitor patient during reversal of anesthesia. Discuss postoperative recovery care with nesthesia and nursing staff. Discuss procedure and outcome with family in waiting area. Examine the patient to ensure no complications have arisen from surgery (e.g. CSF rhinorrhea, orbital hematoma, epistaxis, etc.). Write postoperative note. Dictate operative note and copy to referring physician. Prior to discharge, examine patient and write prescriptions for medications and supplies needed post-discharge. Review post-discharge wound care and activity limitations with patient and family. Dictate discharge summary.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	Wayne Koch, MD; Bradley Marple, MD				
Specialty(s):	otolaryngology				
CPT Code:	31295				
Sample Size:	256	**Resp N:**	33	**Response:** 12.8 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	10.00	**20.00**	50.00	125.00
Survey RVW:	2.50	4.00	**5.00**	6.50	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	15.00	**20.00**	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:	**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: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	31295	**Recommended Physician Work RVU: 2.70**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**30.00**	**33.00**	**-3.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
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
31254	000	4.64	**RUC Time**

CPT Descriptor Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
31233	000	2.18	**RUC Time**

PT Descriptor Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 39.3 %

TIME ESTIMATES (Median)	**CPT Code: 31295**	**Key Reference CPT Code:** 31254	**Source of Time** RUC Time
Median Pre-Service Time	43.00	30.00	
Median Intra-Service Time	20.00	48.00	
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	**78.00**	**108.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.08	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	3.08
Urgency of medical decision making	2.38	2.42
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.38	3.33
Physical effort required	2.85	2.75
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.92	3.50
Outcome depends on the skill and judgment of physician	3.38	3.42
Estimated risk of malpractice suit with poor outcome	2.92	3.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.62	2.67
Intra-Service intensity/complexity	3.15	3.25
Post-Service intensity/complexity	2.23	2.25

Additional Rationale and Comments

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

New code 31295 describes the endoscopic treatment of acute and chronic sinusitis by dilation of the maxillary sinus ostium. The RUC survey data resulted in a median work RVU of 5.00. The AAOHNS expert panel believes this value overstates the total physician work relative to the key reference code 31254 (Nasal/sinus

endoscopy, surgical; with ethmoidectomy, partial (anterior)). The expert panel also believes the total physician work for 31295 is less than 31256 (Nasal/sinus endoscopy, surgical, with maxillary antrostomy;) which is a similar maxillary endoscopy procedure that is more extensive, including tissue excision. Code 31256 (along with any other code that may have been used to report the new code) could not be included in the survey reference list per AMA RUC staff.

In developing a relative work RVU recommendation, the AAOHNS expert panel estimates that the physician work for 31295 is incrementally 25% more total work than the diagnostic maxillary sinus endoscopy code 31233 (Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)) and **recommends 2.70 work RVUs** [2.18 x 125% = 2.70]. This recommendation takes into account the increased complexity and additional pre and post work required for 31295 which is a facility-based procedure compared with 31233 which is primarily performed in an office setting.. The work RVU recommendation of 2.70 places 31295 correctly between 31233 (2.18) and 31256 (3.29).

Additionally, pre-time evaluation and scrub, dress, wait times were reduced from pre-time package 3 so as not to exceed the survey median times for these pre-service components.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
31256 Nasal/sinus endoscopy, surgical, with maxillary antrostomy;
31267 Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus
31299 Unlisted procedure, accessory sinuses
S-2344 Nasal/sinus endoscopy, surgical; with enlargement of sinus ostium opening using inflatable device (i.e. balloon sinuplasty)

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

Specialty otolaryngology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 12000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. As of 4/23/08, approximately 28,500 patients had been treated with balloon dilation in the US over the preceding 3 years (Melroy CT. OTO-HNS 2008;139:S23-S26,). At present, given its increased use, it is reasonable to estimate that annually approximately 20,000 total patients undergo balloon dilation (60% X1-maxillary; 20% X2-frontal; 20% X3-sphenoid).

Specialty otolaryngology Frequency 12000 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? 2,400
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Expert panel estimates that Medicare-aged patients represent 20% of national average.

Specialty otolaryngology Frequency 2400 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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 31525 - similar intra-time and work RVU

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:31296 Tracking Number I7 Specialty Society Recommended RVU: **3.29**
Global Period: 000 RUC Recommended RVU: **3.29**

CPT Descriptor: Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old patient who has failed medical management presents with chronic frontal sinusitis, characterized by frontal discomfort, purulent frontal recess drainage, and/or frontal recess obstruction, is considered a candidate for balloon dilation of the frontal sinus ostium/outflow tract.

Percentage of Survey Respondents who found Vignette to be Typical: 69%

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

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

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

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

Moderate Sedation

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

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 7%

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

Description of Pre-Service Work: Select and order the appropriate antibiotic(s) and confirm timing and administration. 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. Mark sinus side for procedure. Obtain informed consent. 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, endoscopy and video equipment, and anesthesia lines. Ensure that radiographic images are available in the OR. Monitor/assist with prepping and draping. Scrub and gown. Administer intranasal topical anesthetic/vasoconstrictive medication. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: After induction of anesthesia, an intranasal anesthetic/vasoconstrictive agent is injected. Under endoscopic visualization a guide-wire is introduced into the frontal recess via a transnasal approach. A deflated balloon catheter is threaded over the guide wire and introduced into the frontal ostium. Positioning of both the guide-wire and the balloon are confirmed endoscopically (and perhaps with transillumination or via fluoroscopy) during the course of the placement of each. The balloon is then inflated resulting in dilation of the natural ostium of the sinus, displacing bone and mucosa. After dilation the balloon is deflated and removed. In some cases, a separate catheter can be introduced over the guide-wire for irrigation of the sinus.

Description of Post-Service Work: Monitor patient during reversal of anesthesia. Discuss postoperative recovery care with anesthesia and nursing staff. Discuss procedure and outcome with family in waiting area. Examine the patient to ensure no complications have arisen from surgery (e.g. CSF rhinorrhea, orbital hematoma, epistaxis, etc.). Write postoperative note. Dictate operative note and copy to referring physician. Prior to discharge, examine patient and write prescriptior for medications and supplies needed post-discharge. Review post-discharge wound care and activity limitations wit. patient and family. Dictate discharge summary.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010					
Presenter(s):	Wayne Koch, MD; Bradley Marple, MD					
Specialty(s):	otolaryngology					
CPT Code:	31296					
Sample Size:	256	**Resp N:**	35	**Response:** 13.6 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	12.00	**20.00**	40.00	120.00
Survey RVW:	2.35	5.10	**7.00**	8.25	14.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	15.00	25.00	**30.00**	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:	**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: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	31296	**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:		**30.00**	**33.00**	**-3.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-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:	**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? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31255	000	6.95	**RUC Time**

CPT Descriptor Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
31256	000	3.29	**RUC Time**

CPT Descriptor Nasal/sinus endoscopy, surgical, with maxillary antrostomy;

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

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

TIME ESTIMATES (Median)	**CPT Code: 31296**	**Key Reference CPT Code:** 31255	**Source of Time** RUC Time
Median Pre-Service Time	43.00	30.00	
Median Intra-Service Time	30.00	68.00	
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	**88.00**	**128.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.41	4.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.14	4.17
Urgency of medical decision making	2.79	2.75
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.50	4.50
Physical effort required	3.64	3.58
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.07	4.33
Outcome depends on the skill and judgment of physician	4.71	4.42
`stimated risk of malpractice suit with poor outcome	3.93	4.17

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.29	3.23
Intra-Service intensity/complexity	4.14	4.08
Post-Service intensity/complexity	3.00	3.15

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 `ecommendations for the appropriate formula and format.*

New code 31296 describes the endoscopic treatment of acute and chronic sinusitis by dilation of the frontal sinus ostium. The RUC survey data resulted in a median work RVU of 7.00. The AAOHNS expert panel believes this value overstates the total physician work relative to the key reference code 31255 (Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)).

In developing a relative work RVU recommendation, the AAOHNS expert panel identified codes 31231 (Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)) and 31276 (Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus) as "base" and "ceiling" codes in terms of total physician work. However, the base code 31231 (which is typically performed in an office setting) is not analogous to frontal sinus balloon endoscopy (typically performed in a facility).

To place the total work of 31296 relative to other sinus surgical procedures, the expert panel determined that the total work of 31296 would be similar to the total work of 31256 Nasal/sinus endoscopy, surgical, with maxillary antrostomy (RVW=3.29). Although the intra-time for 31256 is greater than 31296, the expertise required and complexity is greater for 31296 (ie, passing the guide wire through the labyrinth of the frontal recess, between lamina (bone over orbit) and cribriform, near the anterior ethmoidal artery).

The expert panel also considered that the recommendation for 31296 should be greater than the recommendations for 3129X1 (RVW=2.70) and 31297 (RVW=2.64); and is approximately three times more work than 31231 (RVW=3.30). Therefore, a work RVU of 3.29 is recommended for 31296. This value appropriately places 31296 relative to the other sinus balloon endoscopy procedures, the same as 31256, and greater than 31231.

Additionally, pre-time evaluation and scrub, dress, wait times were reduced from pre-time package 3 so as not to exceed the survey median times for these pre-service components.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
31276 Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus
31299 Unlisted procedure, accessory sinuses
S-2344 Nasal/sinus endoscopy, surgical; with enlargement of sinus ostium opening using inflatable device (i.e. balloc sinuplasty)

How often do physicians 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 How often?

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. As of 4/23/08, approximately 28,500 patients had been treated with balloon dilation in the US over the preceding 3 years (Melroy CT. OTO-HNS 2008;139:S23-S26,). At present, given its increased use, it is reasonable to estimate that annually approximately 20,000 total patients undergo balloon dilation (60% X1-maxillary; 20% X2-frontal; 20% X3-sphenoid).

Specialty otolaryngology Frequency 4000 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. Expert panel estimates that Medicare-aged patients represent 20% of national average.

Specialty otolaryngology Frequency 800 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 31535 - similar intra-time and work RVU

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:31297 Tracking Number I8 Specialty Society Recommended RVU: **2.64**
Global Period: 000 RUC Recommended RVU: **2.64**

CPT Descriptor: Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old patient who has failed medical management presents with chronic sphenoid sinusitis, characterized by a history of headaches, purulent drainage from the sphenoid ostium, and/or sphenoid ostial obstruction, with possible visual disturbance, is considered a candidate for balloon dilation of the sphenoid ostium.

Percentage of Survey Respondents who found Vignette to be Typical: 69%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 11%

Is moderate 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: Select and order the appropriate antibiotic(s) and confirm timing and administration. 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. Mark sinus side for procedure. Obtain informed consent. 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, endoscopy and video equipment, and anesthesia lines. Ensure that radiographic images are available in the OR. Monitor/assist with prepping and draping. Scrub and gown. Administer intranasal topical anesthetic/vasoconstrictive medication. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: After induction of anesthesia, an intranasal anesthetic/vasoconstrictive agent is injected. Under endoscopic visualization a guide-wire is introduced into the sphenoid ostium via a transnasal approach. A deflated balloon catheter is threaded over the guide wire and introduced into the sphenoid ostium. Positioning of both the guid wire and the balloon are confirmed endoscopically (and perhaps with transillumination or via fluoroscopy) during the course of the placement of each. The balloon is then inflated resulting in dilation of the natural ostium of the sinus, displacing bone and mucosa. After dilation the balloon is deflated and removed. In some cases, a separate catheter can be introduced over the guide-wire for irrigation of the sinus.

Description of Post-Service Work: Monitor patient during reversal of anesthesia. Discuss postoperative recovery care with anesthesia and nursing staff. Discuss procedure and outcome with family in waiting area. Examine the patient to ensure no complications have arisen from surgery (e.g. CSF rhinorrhea, orbital hematoma, epistaxis, etc.). Write postoperative note. Dictate operative note and copy to referring physician. Prior to discharge, examine patient and write prescriptions for medications and supplies needed post-discharge. Review post-discharge wound care and activity limitations with patient and family. Dictate discharge summary.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	Wayne Koch, MD; Bradley Marple, MD				
Specialty(s):	otolaryngology				
CPT Code:	31297				
Sample Size:	256	**Resp N:**	32	**Response:** 12.5 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	6.00	**14.00**	30.00	70.00
Survey RVW:	2.50	4.44	**6.05**	7.13	12.00
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	20.00	**28.00**	30.00	75.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
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: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	31297	**Recommended Physician Work RVU: 2.64**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**30.00**	**33.00**	**-3.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**28.00**		

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
31255	000	6.95	**RUC Time**

CPT Descriptor Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
31235	000	2.64	**RUC Time**

PT Descriptor Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)

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

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 28.1 %

TIME ESTIMATES (Median)	CPT Code: 31297	Key Reference CPT Code: 31255	Source of Time RUC Time
Median Pre-Service Time	43.00	30.00	
Median Intra-Service Time	28.00	68.00	
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	**86.00**	**128.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
Urgency of medical decision making	2.67	2.63
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.33	4.38
Physical effort required	3.44	3.38
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.78	4.50
Outcome depends on the skill and judgment of physician	4.56	4.25
Estimated risk of malpractice suit with poor outcome	4.00	4.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.33	3.25
Intra-Service intensity/complexity	3.78	3.88
Post-Service intensity/complexity	3.00	3.38

Additional Rationale and Comments

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

New code 31297 describes the endoscopic treatment of acute and chronic sinusitis by dilation of the sphenoid. The RUC survey data resulted in a median work RVU of 6.05. The AAOHNS expert panel believes this value

overstates the total physician work relative to the key reference code 31255 (Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)).

In developing a relative work RVU recommendation, the AAOHNS expert panel estimates that the total physician work for 31297 is the same as 31235 (Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)) which may require slightly more intra-time, but less pre and post-work. **A work RVU of 2.64 is recommended.** This recommendation appropriately places 31297 slightly less than 31295, the same as 31235 and less than 31287 (Nasal/sinus endoscopy, surgical, with sphenoidotomy;).

Additionally, pre-time evaluation and scrub, dress, wait times were reduced from pre-time package 3 so as not to exceed the survey median times for these pre-service components.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
31287 Nasal/sinus endoscopy, surgical, with sphenoidotomy;
31288 Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus
31299 Unlisted procedure, accessory sinuses
S-2344 Nasal/sinus endoscopy, surgical; with enlargement of sinus ostium opening using inflatable device (i.e. balloon sinuplasty)

How often do physicians 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 How often?

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. As of 4/23/08, approximately 28,500 patients had been treated with balloon dilation in the US over the preceding 3 years (Melroy CT. OTO-HNS 2008;139:S23-S26,). At present, given its increased use, it is reasonable to estimate that annually approximately 20,000 total patients undergo balloon dilation (60% X1-maxillary; 20% X2-frontal; 20% X3-sphenoid).

Specialty otolaryngology Frequency 4000 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. Expert panel estimates that Medicare-aged patients represent 20% of national average.

Specialty otolaryngology Frequency 800 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 31240 - similar intra-time and work RVU

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 Direct Inputs

CPT Long Descriptor:

31295 Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa

31296 Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)

31297 Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: A panel of AAOHNS members familiar with performing these procedures reviewed the PE details for PEAC reviewed code 31237 and added, deleted, and revised times, supplies and equipment as appropriate.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Diagnostic and referral forms necessary prior to surgery; coordinate with PCP for clearance (eg, change to meds) and with anesthesia services in facility; education/consent provided after decision to undergo procedure; and contact pt prior to procedure to be certain pre-op instructions (diet, meds) are followed.

AMA/Specialty Society RVS Update Process:

Instructions for Specialty Societies Developing Direct PE Input Recommendations for New/Revised Codes

The PEAC has reviewed the pre-service staff times for codes with global periods of 0 and 10 days. The PEAC agreed that a pre-service standard time allocation of 18 minutes for the non-facility and 30 minutes for facility based procedures may apply to a select number of codes. The RUC has agreed that 0 and 10 day codes are assumed to have no pre-service clinical staff time unless the specialty can prove to the RUC that any pre-service time is appropriate. The PEAC agreed that the Specialties will need to justify to the RUC that a code pre-service time is appropriate and whether any standard should be applied.. For a select number of codes, the PEAC adopted the following 0 and 10 day clinical labor standards for a staff blend of RN/LPN/MTA.

	OFF	FAC
Complete pre-service diagnostic & referral forms	5	5
Coordinate pre-service surgery services	3	10
Schedule space and equipment in facility	0	5
Provide pre-service education/obtain consent	7	7
Follow-up phone call and prescriptions	3	3
TOTAL	18	30

Note: The information to the left is from the AMA/RUC instructions files. Per 2010 CMS files, of the ~500 0-day global office-priced codes reviewed by the PEAC/RUC, approx 100 codes have 18/30 min pre-times, including the other office-priced sinoscopy codes; approx 200 codes have zero minutes because they are urgent or performed with and EM on the same day; and the rest of the approx 200 codes have various combinations of pre-time, however, a majority of these codes also include other stafftypes with additional times (eg, RN, rad tech, sonographer).

Intra-Service Clinical Labor Activities:

mparison of times for new codes versus 31237:

Service Period - Start	office 31237	office 31295	office 31296	office 31297	NOTES
Review charts	2	2	2	2	Assemble/review X-ray, lab, path reports (standard for 99213=2)
Greet patient and provide gowning	3	3	3	3	Standard for all office E/M codes 99201-99215
Obtain vital signs	5	5	5	5	4-6 vitals taken
Provide pre-service education/obtain consent	0	0	0	0	included in pre-service work
Prepare room, equipment, supplies	2	2	2	2	set up supplies, including topicals and injectables
Setup scope (non facility setting only)	6	5	5	5	PEAC standard is now 5 minutes
Prepare and position patient/ monitor patient/ set up IV	2	2	2	2	assist with positioning and draping of patient
Sedate/apply anesthesia	7	5	5	5	assist with application of cottonoids/topical, monitor patient while anesthesia takes affect
Intra-service					
Assist physician in performing procedure	40	20	30	28	100% physician time
Post-Service					
Monitor pt. following service/check tubes, monitors, drains	5	2	2	2	Less time needed than 31237 - pt not bleeding
Clean room/equipment by physician staff	3	3	3	3	Standard for all office E/M codes 99201-99215
Clean Scope	7	10	10	10	Standard for rigid scope - entellus flex scope would not require add'l time
Complete diagnostic forms, lab & X-ray requisitions	3	3	3	3	Culture taken and sent to lab
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	3	3	3	3	Review post-procedure instructions, including medications

MEDICAL SUPPLIES	Code	Unit	Office details 31237	31295	31296	31297	NOTES / RATIONALE
pack, minimum multi-specialty visit	SA048	pack	1	1	1	1	same
pack, basic injection	SA041	pack	1	0	0	0	In 2003, this pack was used instead of identifying gown/drape and injection supplies.
GOWN / DRAPE							
cap, surgical	SB001	item		2	2	2	separate listing instead of "injection pack" - more reflective of current practice
gloves, sterile	SB024	pair		2	2	2	
gown, staff, impervious	SB027	item		2	2	2	
mask, surgical	SB033	item		2	2	2	
underpad 2ft x 3ft (Chux)	SB044	item		1	1	1	
towel, non-sterile	SB042	item		2	2	2	
drape, sterile, for Mayo stand	SB012	item		1	1	1	
PROCEDURE							
basin, emesis	SJ010	item	1	1	1	1	same
atomizer tip shield (RhinoGuard)	SM001	item	2	2	2	2	same
oxymetazoline nasal spray (Afrin) (15ml uou)	SJ037	item	2	3	3	3	combination topical anesth/decongestant instead of cocaine
lidocaine 4% soln, topical (Xylocaine)	SH050	ml		3	3	3	
cocaine 4% solution, topical	SH025	ml	4				not typically used in the office for these procedures in current practice
cottonoid	SG031	item	2	5	5	5	needed before procedure and during procedure
cup, medicine (1oz size)	SL037	item		1	1	1	for soaking the cottonoid with drug combination
swab-pad, alcohol	SJ053	item	2	1	1	1	for top of lidocaine vial
lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml		10	10	10	injectable anesthetic
needle, 18-26g 1.5-3.5in, spinal	SC028	item		1	1	1	long needle for injection
needle, 18-27g	SC029	item		1	1	1	drawing needle
syringe 10-12ml	SC051	item		1	1	1	for lidocaine/epi
gauze, sterile 4in x 4in (10 pack uou)	SG056	item		1	1	1	
silver nitrate applicator	SJ046	item	1				not typically used in the office for these procedures in current practice
kit, sinus surgery, balloon (maxillary, frontal, or sphenoid)	$2,087.45	kit		0.5	1	1	Acclarent - 0.5 assumes equal use of kits
kit, sinus surgery, balloon (maxillary)	$1,295.00	kit		0.5			Entellus (MAXILLARY only) - 0.5 assumes equal use of kits
SUCTION							
water, sterile for irrigation (250-1000ml uou)	SH074	item		1	1	1	for syringe irrigation
cup-container, sterile, graduated 1000ml	SL038	item		1	1	1	
syringe 50-60ml	SC056	item		1	1	1	
canister, suction	SD009	item	1	1	1	1	for suction during procedure
tubing, suction, non-latex (6ft uou)	SD132	item	2	1	1	1	
tubing, suction, non-latex (2ft) W/Frazier tip (1)	SD214	item		1	1	1	for suction during procedure (31237 has instrument pack that may have incl frazier tip)
DRESSING							
packing, gauze w-petrolatum, 0.5in (6yd uou)	SG066	item	1				not typically used in the office for these procedures in current practice
MISCELLANEOUS							
tubed culture media	SL146	item		1	1	1	for culture sent to lab
paper, photo printing (8.5 x 11)	SK058	item	2				records more likely are digital
endoscope anti-fog solution	SM014	ml		2	2	2	necessary for scope
EQUIPMENT CLEANING							
pack, cleaning and disinfecting, endoscope	SA042	pack		1	1	1	pack replaces itemized supplies used in 2003
gloves, non-sterile	SB022	pair	1				use pack instead
cleaning brush, endoscope	SM010	item	2				
endoscope anti-fog solution	SM014	ml	2				
enzymatic detergent	SM015	oz	4				
glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz	4				
glutaraldehyde test strips (Cidex, Metrex)	SM019	item	1				

OFFICE DETAILS

EQUIPMENT	Code	Unit	31237	31295	31296	31297	NOTES / RATIONALE
chair with headrest, exam, reclining	EF008		91	55	65	63	Service time MINUS 10 min for scope cleaning
ght, fiberoptic headlight w-source	EQ170		91	55	65	63	
mayo stand	EF015		91	55	65	63	
suction and pressure cabinet, ENT (SMR)	EQ234		91	55	65	63	
video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031		91	55	65	63	
endoscope, rigid, sinoscopy	ES013		91	33	75	73	**Acclarent** - Service time - including scope cleaning (half total time assumes equal use of equipment)
fiberscope, flexible, sinoscopy	2950	new		33	0	0	**Entellus** - Service time - including scope cleaning (half total time assumes equal use of equipment)
instrument pack, medium ($1500 and up)	EQ138		91	0	0	0	reusable instruments >$500 not used for these procedures.

Supply Pricing

ACCLARENT

kit, sinus surgery, balloon (maxillary, frontal, or sphenoid)	**$2,087.45**
sinus surgery balloon catheter	$865.20
sinus surgery guide catheter	$444.00
sinus surgery guide catheter handle	$66.00
sinus surgery illumination guidewire	$454.80
sinus surgery irrigation catheter	$150.00
sinus surgery balloon inflation device	$89.45
inus surgery balloon inflation device extension tubing	$18.00

ENTELLUS

kit, sinus surgery, balloon (maxillary)	**$1,295.00**
maxillary sinus surgery balloon inflation device	
maxillary sinus surgery balloon catheter	
maxillary sinus surgery balloon cannula	
maxillary sinus surgery balloon trocar with sheath	

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

CPT Long Descriptor:

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31296 Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)

31297 Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: A panel of AAOHNS members familiar with performing these procedures reviewed the PE details for PEAC reviewed code 31237 and added, deleted, and revised times, supplies and equipment as appropriate.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Diagnostic and referral forms necessary prior to surgery; schedule space and equipment; coordinate with PCP for clearance (eg, change to meds) and with anesthesia services in facility; education/consent provided after decision to undergo procedure; and contact pt prior to procedure to be certain pre-op instructions (diet, meds) are followed.

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	OFF	FAC
Complete pre-service diagnostic & referral forms	5	**5**
Coordinate pre-service surgery services	3	**10**
Schedule space and equipment in facility	0	**5**
Provide pre-service education/obtain consent	7	**7**
Follow-up phone call and prescriptions	3	**3**
TOTAL	18	**30**

Note: The information to the left is from the AMA/RUC instructions files. Per 2010 CMS files, of the ~500 0-day global office-priced codes reviewed by the PEAC/RUC, approx 100 codes have 18/30 min pre-times, including the other office-priced sinoscopy codes; approx 200 codes have zero minutes because they are urgent or performed with and EM on the same day; and the rest of the approx 200 codes have various combinations of pre-time, however, a majority of these codes also include other stafftypes with additional times (eg, RN, rad tech, sonographer).

Intra AND Post-Service Clinical Labor Activities:

Comparison of times for new codes versus 31237:

	facility 31237	facility 31295	facility 31296	facility 31297	NOTES
SERVICE PERIOD					
Discharge day management	0	6	6	6	If performed in facility, typically same day surgery (Std = 6min)
POST-SERVICE PERIOD					
Conduct phone calls/call in prescriptions	3	0	0	0	Follow-up with patient and/or pharmacy

No Supplies or Equipment

	A	B	C	D	E	F	G	H	I
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**MAXILLARY**		**FRONTAL**		**SPHENOID**	
2	**Meeting Date: February 2010**			**31295**		**31296**		**31297**	
3				Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa		Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)		Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)	
4	**LOCATION**	**Code**	**Staff Type**	**OFF**	**FAC**	**OFF**	**FAC**	**OFF**	**FAC**
5	**GLOBAL PERIOD**			**000**	**000**	**000**	**000**	**000**	**000**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**84**	**36**	**94**	**36**	**92**	**36**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**18**	**30**	**18**	**30**	**18**	**30**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**63**	**6**	**73**	**6**	**71**	**6**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**3**	**0**	**3**	**0**	**3**	**0**
10	**PRE-SERVICE**								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA	**5**	**5**	**5**	**5**	**5**	**5**
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	**3**	**10**	**3**	**10**	**3**	**10**
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA	**0**	**5**	**0**	**5**	**0**	**5**
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**7**	**7**	**7**	**7**	**7**	**7**
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	**3**	**3**	**3**	**3**	**3**	**3**
17	Other Clinical Activity (please specify)	**L037D**	RN/LPN/MTA	**0**	**0**	**0**	**0**	**0**	**0**
18	**End:When patient enters office/facility for surgery/procedure**								
19	**SERVICE PERIOD**								
20	**Start: When patient enters site for procedure: Services Prior to Procedure**								
22	Greet Patient and Provide Gowning, Assure Appropriate Medical Records Are Available	**L037D**	RN/LPN/MTA	**3**		**3**		**3**	
23	Obtain vital signs	**L037D**	RN/LPN/MTA	**5**		**5**		**5**	
24	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**0**		**0**		**0**	
25	Prepare room, equipment, supplies	**L037D**	RN/LPN/MTA	**2**		**2**		**2**	
26	Setup scope (non facility setting only)	**L037D**	RN/LPN/MTA	**5**		**5**		**5**	
27	Prepare and position patient/ monitor patient/ set up IV	**L037D**	RN/LPN/MTA	**2**		**2**		**2**	
28	Sedate/apply anesthesia	**L037D**	RN/LPN/MTA	**5**		**5**		**5**	
29	**Intra-service**								
30	Assist physician in performing procedure	**L037D**	RN/LPN/MTA	**20**		**30**		**28**	
31	**Post-Service**								
32	Monitor pt following service/check tubes, monitors, drains	**L037D**	RN/LPN/MTA	**2**		**2**		**2**	
33	Clean room/equipment by physician staff	**L037D**	RN/LPN/MTA	**3**		**3**		**3**	
34	Clean Scope	**L037D**	RN/LPN/MTA	**10**		**10**		**10**	
35	Clean Surgical Instrument Package	**L037D**	RN/LPN/MTA						
36	Complete diagnostic forms, lab & X-ray requisitions	**L037D**	RN/LPN/MTA	**3**		**3**		**3**	
37	Review/read X-ray, lab, and pathology reports	**L037D**	RN/LPN/MTA						
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	**L037D**	RN/LPN/MTA	**3**		**3**		**3**	
39	Discharge day management	**L037D**	RN/LPN/MTA		**6**		**6**		**6**
41	**End: Patient leaves office**								
42	**POST-SERVICE Period**								
43	**Start: Patient leaves office/facility**								
44	Conduct phone calls/call in prescriptions			**3**	**0**	**3**	**0**	**3**	**0**
55	**End: with last office visit before end of global period**								

	A	B	C	D	E	F	G	H	I
1	**AMA/Specialty Society RVS Update Committee Recommendation**			MAXILLARY		FRONTAL		SPHENOID	
2	**Meeting Date: February 2010**			31295		31296		31297	
3				Nasal/sinus endoscopy, surgical, with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa		Nasal/sinus endoscopy, surgical, with dilation of frontal sinus ostium (eg, balloon dilation)		Nasal/sinus endoscopy, surgical, with dilation of sphenoid sinus ostium (eg, balloon dilation)	
4	**LOCATION**	**Code**	**Staff Type**	**OFF**	**FAC**	**OFF**	**FAC**	**OFF**	**FAC**
56	**MEDICAL SUPPLIES**	**Code**	**Unit**						
57	pack, minimum multi-specialty visit	SA048	pack	1		1		1	
58	pack, basic injection	SA041	pack	0		0		0	
59	**GOWN / DRAPE**								
60									
61	gloves, sterile	SB024	pair	2		2		2	
62	gown, staff, impervious	SB027	item	2		2		2	
63	mask, surgical	SB033	item	2		2		2	
64	underpad 2ft x 3ft (Chux)	SB044	item	1		1		1	
65	towel, non-sterile	SB042	item	2		2		2	
66	drape, sterile, for Mayo stand	SB012	item	1		1		1	
67	**PROCEDURE**								
68	basin, emesis	SJ010	item	1		1		1	
69	atomizer tip shield (RhinoGuard)	SM001	item	2		2		2	
70	oxymetazoline nasal spray (Afrin) (15ml uou)	SJ037	item	3		3		3	
71	lidocaine 4% soln, topical (Xylocaine)	SH050	ml	3		3		3	
72	cocaine 4% solution, topical	SH025	ml						
73	cottonoid	SG031	item	5		5		5	
74	cup, medicine (1oz size)	SL037	item	1		1		1	
75	swab-pad, alcohol	SJ053	item	1		1		1	
76	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml	10		10		10	
77	needle, 18-26g 1 5-3.5in, spinal	SC028	item	1		1		1	
78	needle, 18-27g	SC029	item	1		1		1	
79	syringe 10-12ml	SC051	item	1		1		1	
80	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		1		1	
81	silver nitrate applicator	SJ046	item						
82	kit, sinus surgery, balloon (maxillary, frontal, or sphenoid)	$2,087.45	kit	0.5		1		1	
83	kit, sinus surgery, balloon (maxillary)	$1,295.00	kit	0.5					
84	**SUCTION**								
85	water, sterile for irrigation (250-1000ml uou)	SH074	item	1		1		1	
86	cup-container, sterile, graduated 1000ml	SL038	item	1		1		1	
87	syringe 50-60ml	SC056	item	1		1		1	
88	canister, suction	SD009	item	1		1		1	
89	tubing, suction, non-latex (6ft uou)	SD132	item	1		1		1	
90	tubing, suction, non-latex (2ft) with Frazier tip (1)	SD214	item	1		1		1	
91	**DRESSING**								
92	packing, gauze w-petrolatum, 0 5in (6yd uou)	SG066	item						
93	**MISCELLANEOUS**								
94	tubed culture media	SL146	item	1		1		1	
95	paper, photo printing (8 5 x 11)	SK058	item						
96	endoscope anti-fog solution	SM014	ml	2		2		2	
97	**EQUIPMENT CLEANING**								
98	pack, cleaning and disinfecting, endoscope	SA042	pack	1		1		1	
99	gloves, non-sterile	SB022	pair						
100	cleaning brush, endoscope	SM010	item						
101	endoscope anti-fog solution	SM014	ml						
102	enzymatic detergent	SM015	oz						
103	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz						
104	glutaraldehyde test strips (Cidex, Metrex)	SM019	item						
105	**Equipment**	**Code**							
106	chair with headrest, exam, reclining	EF008		53		63		61	
107	light, fiberoptic headlight w-source	EQ170		53		63		61	
108	mayo stand	EF015		53		63		61	
109	suction and pressure cabinet, ENT (SMR)	EQ234		53		63		61	
110	video system, endoscopy (processor, digital capture, monitor, printer, cart)	ES031		53		63		61	
111	endoscope, rigid, sinoscopy	ES013		31.5		73		71	
112	fiberscope, flexible, sinoscopy	$2,950	new	31.5					
113	instrument pack, medium ($1500 and up)	EQ138		0		0		0	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2010

Bronchoscopy with Balloon Occlusion

In October 2009, the CPT Editorial Panel created a new CPT code to describe a bronchoscopic technique that is performed as part of a last resort effort to resolve persistent bronchopleural fistulas.

The RUC reviewed the specialty survey results from 32 pulmonologists who were familiar with new procedure 31634 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak with administration of occlusive substance (eg, fibrin glue), if performed*, and agreed the physician time components reflected they typical service time. The RUC compared the surveyed code to key reference code 31629 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)* (000 day global, work RVU = 4.09) and determined they were similar in intensity, complexity, and overall physician time. The specialty indicated that code 31629 is one of the most intense procedures performed by pulmonologists and that 31634 is typically performed in the intensive care unit. In addition, 78% of the respondents agreed with the typical patient vignette. The RUC agreed the specialty survey results, median work RVU, and the recommended physician time components are reflective of the service.

The RUC also reviewed code 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* (000 day global, work RVU = 3.80, intra-service time = 40 minutes) in relation to new procedure 31634 and agreed that the survey code is a more intense procedure to perform. The RUC agreed that upon review of reference services the median value of 4.00 accurately reflects the physician work value of new code 31634, and is rank ordered within this family of codes. **The RUC recommends a relative work value of 4.00 for CPT Code 31634.**

Practice Expense: The RUC reviewed the direct practice expense inputs recommendation for the facility and non-facility settings and made minor edits to reflect the typical patient scenario.

New Technology: The RUC considers CPT code 31634 be placed on the RUC's new technology listing.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
◎*31622*		Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	000	2.78 (No Change)
●◎31634	J1	with balloon occlusion, with assessment of air leak with administration of occlusive substance (eg, fibrin glue), if performed	000	4.00

72

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:31634 Tracking Number J1 Specialty Society Recommended RVU: **4.00**
Global Period: 000 RUC Recommended RVU: **4.00**

CPT Descriptor: Bronchoscopy, rigid or flexible, including fluroscopic guidance, when performed; with balloon occlusion and assessment of air leak includes administration of occlusive substance (eg, fibrin glue), when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male with pneumonia and respiratory failure on a mechanical ventilator develops a pneumothorax with a persistent air leak on the right side presumed to be a bronchopleural fistula.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

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

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

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

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

Ioderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 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? 22%

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 disposable gown, non-sterile gloves, and protective eyewear before the procedure. 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 bnormalities. The vocal cords are visualized and the structure and funciton are noted. Patient undergoes systematic alloon occlusion of bronchial subsegments with measurements of the air leak after each occlusion with the placement of glue or sealant.

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, mucus 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 instrucitons about post-procedure complications. The physician generates a detailed report of the procedure. The physician communicates results to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	Alan Plummer, MD (ATS), Scott Manaker, MD, PhD (ACCP) and Burt Lesnick, MD (ACCP)				
Specialty(s):	Pulmonary Medicine				
CPT Code:	31634				
Sample Size:	50	**Resp N:**	32	**Response:** 64.0 %	
Sample Type:	Panel	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	2.00	**3.50**	5.00	20.00
Survey RVW:	0.90	3.52	**4.00**	4.15	7.60
Pre-Service Evaluation Time:			**17.50**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	2.00	30.00	**45.00**	56.25	90.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
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-FAC Straightforw Pat Procedure(w sedate/anes)

CPT Code:	31634	**Recommended Physician Work RVU: 4.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**19.00**	**19.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**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 fluroscopic guidance, when performed; 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, with fluroscopic guidance, when performed; 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, with fluroscopic guidance, when performed; with transbrochial 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: 17 **% of respondents:** 53.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 31634**	**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	20.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	**90.00**	**80.00**
Other time if appropriate		

NTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.78	3.47
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.69	4.18
Urgency of medical decision making	3.31	3.12
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.75	3.76
Physical effort required	4.18	3.82
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.25	3.81
utcome depends on the skill and judgment of physician	4.65	4.41
Estimated risk of malpractice suit with poor outcome	3.94	3.88

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.06	3.24
Intra-Service intensity/complexity	4.71	4.47
Post-Service intensity/complexity	3.65	3.24

Additional Rationale and Comments

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 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: No

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

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

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

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

How often do physicians 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? 1000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We compared to the frequency of 31626 recently surveyed.

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. We compared to the frequency of 31626 recently surveyed.

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? (ie. similar work RVU, and specialty) Yes

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

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

	A	B	C	D	E
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**31634**	
2	**Meeting Date: February 4-7, 2010 Orlando, FL**	**CMS**	**Staff**	**Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion and assessment of air leak includes administration of occlusive substance (eg, fibrin glue), when performed**	
3	**American College of Chest Physician (ACCP) and the American Thoracic Society (ATS)**	**Code**	**Type**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**0**	**0**
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	15.0
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**16.0**	**15.0**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**159.0**	**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	L047C	RN/RT		**3**
15	Provide pre-service education/obtain consent	L047C	RN/RT	**5**	
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		
22	Greet patient and provide gowning, ensure appropriate medical records are available	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	Clean Surgical Instrument Package				
37	Complete diagnostic forms, lab & X-ray requisitions	L047C	RN/RT	**4**	
38	Review/read X-ray, lab, and pathology reports				
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L047C	RN/RT	**3**	
40	Discharge day management				
41	Other Clinical Activity (please specify)				
42	**End: Patient leaves office**				

	A	B	C	D	E
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**31634**	
2	**Meeting Date: February 4-7, 2010 Orlando, FL**	**CMS**	**Staff**	**Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion and assessment of air leak includes administration of occlusive substance (eg, fibrin glue), when performed**	
3	**American College of Chest Physician (ACCP) and the American Thoracic Society (ATS)**	**Code**	**Type**	**Non Facility**	**Facility**
43	**MEDICAL SUPPLIES**		**Unit**		
44					
45	suction specimen trap, sterile	SD121	1	**1**	
46	syringe 10-12 ml	SC051	2	**2**	
47	eye shield, splash protection	SM016	2	**2**	
48	pack, cleaning and disinfecting, endoscope	SA042	1	**1**	
49	pack, conscious sedation	SA044	1	**1**	
50	Pack, minimum multi-specialty visit	SA048	1	**1**	
51	syringe, 50-60ml sliptip (1)	SC056	1	**1**	
52	cup, biopsy-specimen sterile 4 oz	SL036	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	Transbronchial needle - cytology (58.05)				
60	Tisseel Fibrin Glue, 4ml #1501262, $205.50 (email quote provided)			**4ml**	
61	B5-2C Double Lumen Balloon 10 mm dia, $126 75 (invoice provided)			**1**	
62	Insuffalator - Boston Scientific cost $85 (quote provided)			**1**	
63	gauze, sterile 4in x 4in (10 pack uou)	SG056	10 pack	**2**	
64	**Equipment**				
65	table, power	EF031	1	**85**	
66	ECG, 3-channel (with Sp02)	EQ011	1	**85**	
67	IV infusion pump	EQ032	1	**85**	
68	pulse oximeter with printer	EQ211	1	**85**	
69	suction machine (Gomco)	EQ235	1	**85**	
70	fluoroscopic system, mobile C	ER031	1	**85**	
71	fiberscope, flexible, bronchoscope	ES017	1	**112**	
72	videosystem, endoscopy	ES031	1	**85**	
73					

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2010

Cardiac Hybrid Procedures

In November 2009, the CPT Editorial Panel created three new codes to represent new operations that use a hybrid approach to treating neonates and infants for congenital cardiac diseases. All three procedures are generally performed on a patient but at different stages during the patient's development.

33620 ***Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)***
New procedure 33620 is typically performed in conjunction with 33621 *Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)* and with a cardiologist, who will separately bill for stent insertion (37207 *Transcatheter placement of an intravascular stent(s) (non-coronary vessel), open; initial vessel* (Work RVU = 8.27)). This procedure is also performed as a stand alone procedure or in a staged manner with 33621. When this procedure is performed with 33621, the multiple procedure reduction would apply for the surgeon, who would bill 33620 and 33621.

87

The RUC reviewed specialty survey data from 20 physicians who were familiar with this new stage 1 procedure. The RUC understood that this procedure is rarely performed, estimated to be 100 times yearly for the non-Medicare population, and the typical patient is a newborn. The RUC was therefore comfortable with the number of survey respondents.

The RUC reviewed the specialty survey results and recommended physician time components, and agreed they accurately reflected the time required to perform the service. The RUC compared the surveyed code to its reference service code 33690 *Banding of pulmonary artery* (Work RVU = 20.36, 120 minutes of intra-service time) which had the same intra-service time. The RUC noted that the survey respondents indicated the intensity and complexity of this new procedure was greater than code the new code's key reference service. The RUC also reviewed the similarities with multi-specialty points of comparison codes 33533 *Coronary artery bypass, using arterial graft(s); single arterial graft* (Work RVU = 33.75, 151 minutes of intra-service time) and 33681 *Closure of single ventricular septal defect, with or without patch;* (Work RVU = 32.34, 150 minutes of intra-service time) in relation to new code 33620. The RUC agreed that while these services have greater intra-service time, the intensity and complexity, along with similarities in total time, of the surveyed code is greater and should be valued similarly.

Based on comparisons to the reference codes with regard to the specialty survey data and physician work and time comparisons, the survey median of 30.00 work RVUs is appropriate and maintains rank order amongst similar services. **The RUC recommends a relative work value of 30.00 for CPT code 33620.**

33621 ***Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)***
The RUC discussed the physician work of new code 33621 *Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)* in relation to code 33620 *Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)* as it is a staged procedure. RUC members concurred that four level one hospital visits should be removed from the specialty recommended physician time and work of code 33621, as well as the discharge day management since these activities were considered duplicative with the work post operatively of 33620. After the subtraction of this work, the RUC agreed that the work value of 33621 would be 16.18.

The RUC also discussed and agreed that the pre-service evaluation time of 40 minutes was justified for this procedure given the complexity and incremental work involved. In addition, the specialty had adjusted this pre time from over 90 minutes in order to fit into the standard pre-time package. The RUC reviewed several services in relation to the work value of 16.18 for 33621. Two specific services were identified as having similar intensity, complexity, and physician time. These codes are: 33320 Suture repair of aorta or great vessels; without shunt or cardiopulmonary bypass (work RVU = 18.54) and 32100 *Thoracotomy, major; with exploration and biopsy* (work RVU = 16.16, 100 minutes intra service time, IWPUT = 0.0658), 50040 *Nephrostomy, nephrotomy with drainage* (work RVU = 16.68, 90 minutes intra-service time). **The RUC recommends a relative work value for CPT code 33621 of 16.18.**

33622 ***Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)***
The RUC reviewed specialty survey data from 20 physicians who were familiar with this new stage 2 procedure. Most survey respondents indicated the intensity and complexity of this new procedure are quite similar to code 33783 *Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); with reimplantation of 1 or both coronary ostia* (Work RVU = 65.08, 360 minutes of intra-service time), which was selected as the new code's key reference service. The RUC also reviewed the similarities with multi-specialty points of comparison codes 61697 *Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation* (Work RVU = 63.22, 300 minutes of intra-service time) and 33863 *Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction* (Work RVU = 58.71, 287 minutes of intra-service time) in relation to new code 33622. **The RUC recommends a relative work value for CPT code 33622 of 64.00.**

Practice Expense: The RUC reviewed and agreed with the specialty recommended 090 day global standard direct practice expense inputs for these three new procedures performed only in the facility setting.

New Technology: The RUC considers CPT codes 33620, 33621, and 33622 be placed on the RUC's new technology listing.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•33620	K1	Application of right and left pulmonary artery bands (eg, hybrid approach stage 1) (For pulmonary artery banding related to septal defect, use 33690)	090	30.00
•33621	K2	Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1) (To report placement of stent, use 37207) (Report both 33620, 33621 if performed in same session)	090	16.18
•33622	K3	Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding) (Do not report 33622 in conjunction with 33619, 33767, 33822, 33840, 33845, 33851, 33853, 33917) (For bilateral, bidirectional Glenn procedure, use 33622 in conjunction with 33768)	090	64.00

89

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33620 Tracking Number K1 Specialty Society Recommended RVU: **30**
Global Period: 090 RUC Recommended RVU: **30**

CPT Descriptor: Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)

(For pulmonary artery banding related to septal defect, use 33690)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A newborn baby presents with cyanosis and hypotension. Echocardiography documents Hypoplastic Left Heart Syndrome (HLHS) with aortic atresia and mitral atresia and a large atrial septal defect. The child is medically stabilized with a Prostaglandin infusion. The family and medical team elect to treat the child with the Hybrid Approach. The patient is taken to the operating theater on day of life 5 at a weight of 2500 grams to undergo the following operation: Application of right and left pulmonary artery bands (eg. Hybrid Approach "Stage I")

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work: Review pre-operative data including radiology, cardiac catheterization (in some cases), ECHO Cardiograms, laboratory findings and other data. Write the pre-operative orders for the peri-operative medications. Confirm OR start time and notify the patient and the family. Arrange for surgical assistant and check with Lab on availability of blood and or x-ray machine. Review the anesthesia length and type with the anesthesiologist. Obtain informed consent and review planned incisions, planned procedure, positioning and draping, and post-op recovery in and out of the hospital. Answer patient and family questions. Verify that all necessary surgical instruments, supplies and devices are available in the operative suite. Monitor the patient positioning and draping and assist with positioning as needed. Scrub and gown. Observe and/or assist in insertion of monitoring lines and induction of anesthesia.

Description of Intra-Service Work: Under general endotracheal anesthesia, in the supine position, the patient is prepp and draped in standard aseptic fashion. Skin incision made via standard median sternotomy. Sternum is divided in the midline. A thymectomy is performed. The pericardium is opened and the right and left branch pulmonary arteries are dissected and exposed. A band is placed around the left pulmonary artery and then a second band is placed around the right pulmonary artery. Hemodynamic stability and oxygen saturation are assessed. Chest tubes and temporary pacing wires are

placed. Pericardial substitute membrane is placed to aid in future median sternotomies. The sternum is closed with wires, the abdominal fascia, skin and subcutaneous tissue closed in layers. Sterile dressing is applies and the patient is stabilized and transferred to the ICU.

Description of Post-Service Work: Accompany patient from operating room to intensive care unit. Discuss procedure outcome with family, and the referring physician. Coordinate care with other necessary physicians. Dictate operative report. Sign OR forms and write post-op orders for medications, labs, and nursing staff post operative care. Answer nursing and other staff questions. Visit patient during the posteoperative period as necessary to examine wounds and monitor patient progress and answer any of the family's questions. Write discharge orders for patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010		
Presenter(s):	John Mayer, MD		
Specialty(s):	STS/AATS		
CPT Code:	33620		
Sample Size:	100	**Resp N:** 20	**Response:** 20.0 %
Sample Type:	Random	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	4.00	8.00
Survey RVW:	20.00	22.00	**30.00**	35.00	42.00
Pre-Service Evaluation Time:			**70.00**		
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:	**60.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**235.00**	99231x **5.00** 99232x **2.00** 99233x **1.00**
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(3ε 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:	33620	**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:		**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:	**60.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**235.00**	99231x **5.00** 99232x **2.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 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? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33690	090	20.36	**RUC Time**

CPT Descriptor Banding of pulmonary artery

(Do not report modifier 63 in conjunction with 33690)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
33533	090	33.64	**RUC Time**	88,342

CPT Descriptor 1 Coronary artery bypass, using arterial graft(s); single arterial graft

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
33681	090	32.16	**RUC Time**	163

CPT Descriptor 2 Closure of single ventricular septal defect, with or without patch;

Other Reference CPT Code	Global	Work RVU	Time Source
33660	090	31.83	**RUC Time**

CPT Descriptor Repair of incomplete or partial atrioventricular canal (ostium primum atrial septal defect), with or without atrioventricular valve repair

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 75.0 **%**

TIME ESTIMATES (Median)	CPT Code: 33620	Key Reference CPT Code: 33690	Source of Time RUC Time
Median Pre-Service Time	63.00	120.00	
Median Intra-Service Time	120.00	120.00	
Median Immediate Post-service Time	60.00	300.00	
Median Critical Care Time	70.0	0.00	
Median Other Hospital Visit Time	235.0	0.00	
Median Discharge Day Management Time	38.0	0.00	
Median Office Visit Time	23.0	80.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**609.00**	**620.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.86	2.91
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.64	2.91
Urgency of medical decision making	3.64	2.91
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.64	2.91
Physical effort required	3.07	2.46
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.14	3.36
Outcome depends on the skill and judgment of physician	4.14	3.45
Estimated risk of malpractice suit with poor outcome	3.50	3.55

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.79	2.91
Intra-Service intensity/complexity	3.64	2.91
Post-Service intensity/complexity	3.86	3.18

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 Valu Recommendations for the appropriate formula and format.*

The STS recommends that the 50th percentile be used for the RVW and the intraservice time data components for this procedure. This procedure is typically done in conjunction with X1 and with a cardiologist, who will separately bill for stent insertion (37207). This procedure is also performed as a stand alone procedure or in a staged manner with 33621.

When this procedure is performed with 33621, the multiple procedure reduction would apply for the surgeon, who would bill 33620 and 33621. The table demonstrates that the 50% reduction is sufficient and appropriate, with RUC reviewed reference codes provided for the combined procedure (removing the pre and post time and visits from 33621). This is a new approach to treatment of this disease process and it is still evolving as to the typical process of care. Thus, it is important to maintain 33620 as an independent code, and not incorporate 33621 into the code, because it is likely that advances in technology will permit 33621to be performed percutaneously in these neonatal patients. This will increase the frequency of use of 33620 as a stand alone procedure, and it will become typical.

SERVICES REPORTED WITH MULTIPLE 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 may be commonly performed with code 3362X1

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

	33620	33621	Together with 50% reduction	Reference 33427	37207
Global	090	090	090	090	000
	Performed by	ct surgeon	ct surgeon	ct surgeon	cardiologist
RVW	30	20.5	40.25	44.27	8.27
	Pre time	63	63	63	95
	65				
	Intra time	120	95	215	221
108					
Post time	60	53	60	40	35
HV Time	305	210	305	280	0
OV Time	23	23	23	63	0
IWPUT	0.1017	0.0645	0.1044	0.1190	0.0585

Additional IWPUT calculation of code 33621 as intraservice time only (ZZZ) with reference code

	33620 as ZZZ	35500 as Reference
Global	ZZZ	ZZZ
RVW	10.25	6.44
Intra Time	95	60
IWPUT	0.1079	0.1073

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33999 or 33690

How often do physicians 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? 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 proceudre is a congenital cardiac procedure specific to the infant population

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. Code 33660 is a more representative crosswalk than the reference code since 33660 is performed by the same specialty and has a similar RVW.

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:33621 Tracking Number K2 Specialty Society Recommended RVU: **18.50**
Global Period: 090 RUC Recommended RVU: **16.18**

CPT Descriptor: Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)
(To report placement of stent, use 37207)
(Report both 33620 and 33621 if performed in same session)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A newborn baby presents with cyanosis and hypotension. Echocardiography documents Hypoplastic Left Heart Syndrome (HLHS) with aortic atresia and mitral atresia and a large atrial septal defect. The child is medically stabilized with a Prostaglandin infusion. The family and medical team elect to treat the child with the Hybrid Approach. The patient is taken to the operating theater on day of life 5 at a weight of 2500 grams to undergo the following operation: Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg Hybrid approach "Stage I"). Stent placement is reported separately.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work: Review pre-operative data including radiology, cardiac catheterization (in some cases), ECHO Cardiograms, laboratory findings and other data. Write the pre-operative orders for the peri-operative medications. Confirm OR start time and notify the patient and the family. Arrange for surgical assistant and check with Lab on availability of blood and or x-ray machine. Review the anesthesia length and type with the anesthesiologist. Obtain informed consent and review planned incisions, planned procedure, positioning and draping, and post-op recovery in and out of the hospital. Answer patient and family questions. Verify that all necessary surgical instruments, supplies and devices are available in the operative suite. Monitor the patient positioning and draping and assist with positioning as needed. Scrub and gown. Observe and/or assist in insertion of monitoring lines and induction of anesthesia.

Description of Intra-Service Work: 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. A thymectomy is performed. The pericardium is opened and the anterior and ventricular surfaces at the ventricular outlet are dissected and exposed. Pursestring sutures are placed in the anterior ventricular surface at the ventricular outlet. A Catheter is placed through the pursestring into the heart. Under fluoroscopic guidance a guidewire is advanced through the catheter and the pulmonary valve into the patent ductus arteriosus. The surgeon stands by while the interventional cardiologist places the stent into the patent ductus arteriousus. Fluoroscopy is used to assess the adequacy of the ste position. Hemodynamic stability and oxygen saturation are assessed and ovserved. Chest tubes and temporary pacing wire are placed. Pericardial substitute membrane is placed to aid in future median sternotomies. The sternum is closed with wires, the abdominal fascia, skin and subcutaneous tissue closed in layers. Sterile dressing is applies and the patient is stabilized and transferred to the ICU.

Description of Post-Service Work: Accompany patient from operating room to intensive care unit. Discuss procedure outcome with family, and the referring physician. Coordinate care with other necessary physicians. Dictate operative report. Sign OR forms and write post-op orders for medications, labs, and nursing staff post operative care. Answer nursing and other staff questions. Visit patient during the posteoperative period as necessary to examine wounds and monitor patient progress and answer any of the family's questions. Write discharge orders for patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	John Mayer, MD				
Specialty(s):	STS/AATS				
CPT Code:	33621				
Sample Size:	100	**Resp N:**	19	**Response:** 19.0 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**2.00**	4.00	8.00
Survey RVW:	16.00	20.00	**20.50**	28.50	42.00
Pre-Service Evaluation Time:			**98.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**22.50**		
Intra-Service Time:	30.00	68.00	**95.00**	120.00	150.00

Immediate Post Service-Time:	**52.50**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**140.00**	99231x **7.00** 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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	33621	**Recommended Physician Work RVU: 16.18**		
		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:		**95.00**		

Immediate Post Service-Time:	**52.50**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**60.00**	99231x **3.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
ffice 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? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33320	090	18.54	**Harvard Time**

CPT Descriptor Suture repair of aorta or great vessels; without shunt or cardiopulmonary bypass

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
49002	090	17.55	**RUC Time**	5,696

CPT Descriptor 1 Reopening of recent laparotomy

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
32654	090	20.44	**RUC Time**	127

CPT Descriptor 2 Thoracoscopy, surgical; with control of traumatic hemorrhage

Other Reference CPT Code	Global	Work RVU	Time Source
33690	090	20.36	**RUC Time**

CPT Descriptor Banding of pulmonary artery

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 57.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 33621**	**Key Reference CPT Code:** 33320	**Source of Time Harvard Time**
Median Pre-Service Time	63.00	62.00	
Median Intra-Service Time	95.00	129.00	
Median Immediate Post-service Time	52.50	53.00	
Median Critical Care Time	70.0	70.00	
Median Other Hospital Visit Time	60.0	168.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	23.0	34.50	
Prolonged Services Time	0.0	0.00	
Median Total Time	**363.50**	**516.50**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.64	2.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.73	2.67
Urgency of medical decision making	3.45	3.22
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	2.89
Physical effort required	2.55	2.44
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.73	3.11
Outcome depends on the skill and judgment of physician	3.82	3.44
'stimated risk of malpractice suit with poor outcome	3.45	3.44

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.64	2.89
Intra-Service intensity/complexity	3.18	3.22
Post-Service intensity/complexity	3.64	3.00

Additional Rationale and Comments

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

The STS recommends that the 50th percentile be used for the RVW and the intraservice time data components for this procedure. This procedure is typically done with a cardiologist, who will separately bill for stent insertion (37207). This procedure is also performed as a stand alone procedure, in a staged manner with 33620, or in the same session with the 33620. When this procedure is performed with 33620, the multiple procedure reduction would apply for the surgeon, who

would bill 33620 and 33621. The table demonstrates that the 50% reduction is sufficient and appropriate, with RUC reviewed reference codes provided for the combined procedure (removing the pre and post time and visits from 33621) and for 33621 valued as a ZZZ code with no pre- or post-time. This is a new approach to treatment of this disease process and it is still evolving as to the typical process of care. Thus, it is important to maintain 33620 as an independent code, and not incorporate 33621 into the code, because it is likely that advances in technology will permit 33621 to be performe percutaneously in these neonatal patients.

SERVICES REPORTED WITH MULTIPLE 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 may be commonly performed with code 33620

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

3.		33620	33621	Together with 50% reduction	Reference 33427	37207
4.	Global	090	090	090	090	000
5.	Performed by	ct surgeon	ct surgeon	ct surgeon		cardiologist
6.	RVW	30	20.5	40.25	44.27	8.27
7.	Pre time	63	63	63	95	65
8.	Intra time	120	95	215	221	
	108					
9.	Post time	60	53	60	40	35
10.	HV Time	305	210	305	280	0
11.	OV Time	23	23	23	63	0
12.	IWPUT	0.1017	0.0645	0.1044	0.1190	
	0.0585					

Additional IWPUT calculation of code 3362X1 as intraservice time only (ZZZ) with reference code

	33620 as ZZZ	35500 as Reference
Global	ZZZ	ZZZ
RVW	10.25	6.44
Intra Time	95	60
IWPUT	0.1079	0.1073

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? 90
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 90 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. Please explain the rationale for this estimate. This proceudre is a congenital cardiac procedure specific to the infant population

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

pecialty 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? (ie. similar work RVU, and specialty) 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:33622 Tracking Number K3 Specialty Society Recommended RVU: **64.00**
Global Period: 090 RUC Recommended RVU: **64.00**

CPT Descriptor: Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)
(Do not report 33622 in conjunction with 33619, 33767, 33822, 33840, 33845, 33851, 33853, 33917)

(For bilateral, bidirectional Glenn procedure, use 33622 in conjunction with 33768)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A newborn baby presented with cyanosis and hypotension. Echocardiography documented Hypoplastic Left Heart Syndrome (HLHS) with aortic atresia and mitral atresia and a large atrial septal defect. The child was medically stabilized with a Prostaglandin infusion. The family and medical team elected to treat the child with the Hybrid Approach. On day of life 5 at a weight of 2500 grams, the patient was taken to the hybrid suite and underwent placement of bilateral pulmonary artery bands and ductal stenting. After spending 10 days in the cardiac intensive care unit, the child is discharged to home.
The infant does well at home at grows and thrives. At the age of 4 months, the child weighs 5500 grams. Cardiac catheterization demonstrates that the patient is a suitable candidate for "Hybrid Stage 2". The patients is taken to the operating theater to undergo the following operation: Reconstruction of complex cardiac anomaly (eg; single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis second superior vena cava, and removal of right and left pulmonary bands (eg Hybr approach "Stage 2" Norwood Stage 1, Bidirectional Glenn, and PA debanding)
(Report 33768 in conjunction to 33622 to report a bilateral, bidirectional Glenn)

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work: Review pre-operative data including radiology, cardiac catheterization (in some cases), ECHO Cardiograms, laboratory findings and other data. Write the pre-operative orders for the peri-operative medications. Confirm OR start time and notify the patient and the family. Arrange for surgical assistant and check with Lab on availability of blood and or x-ray machine. Review the anesthesia length and type with the anesthesiologist. Obtain ıformed consent and review planned incisions, planned procedure, positioning and draping, and post-op recovery in and out of the hospital. Answer patient and family questions. Verify that all necessary surgical instruments, supplies and devices are available in the operative suite. Monitor the patient positioning and draping and assist with positioning as needed. Scrub and gown. Observe and/or assist in insertion of monitoring lines and induction of anesthesia.

Description of Intra-Service Work: Under general endotracheal anesthesia, in the supine position, the patient is prepped and draped in standard aseptic fashion. Skin incision made through previous median sternotomy site. Sternum is divided in the midline. The old pericardial substitute membrane is removed. The right atrium, pulmonary artery, aortic arch, and ductus arteriosus are dissected and exposed. Cardiac cannulas are placed and Cardiopulmonary bypass initiated. The ductus arteriosus is controlled and the patient is cooled to 18 degrees centigrade for a period of 20 minutes on cardiopulmonary bypass. Tapes are placed around the superior vena cava and inferior vena cava while the patient is cooling. In addition a complete dissection of the aortic arch, the innominate artery, the left carotid artery, the left subclativan artery, and the proximal descending thoracic aorta is performed preserving the left vegas, the left phrenic and the left recurrent laryngeal nerves. The aorta is crossclamped and cold cardioplegic solution is infused into the aortic root. The right atrium is opened and an atrial septectomy is performed. A vent is placed through the right atrium into the left atrium and circulatory arrest is established. The ductal tissue is excised and the ductal stent removed. The main pulmonary artery distal to the pulmonary (neoaortic) valve is transected. The right and left branch pulmonary arteries are fully dissected and mobilized. The right pulmonary artery band is removed (PA debanding) and then the left pulmonary artery band is removed. The right pulmonary artery is opened where the superior cavopulmonary anastomosis will be created. The caliber of the branch pulmonary arteries are assessed and they are probed. A patch pulmonary arteriolasty is performed if necessary. The ascending to the descending aorta is opened and the aortic arch is reconstructed. The ascending aorta is anastomosed to the proximal main pulmonary artery and a neoaorta and "aortopulmonary amalgamation" are created. The aorta is recannulated and cardiopulmonary bypass is reestablished. The atriotomy is now closed, air is evacuated from the ·ardiac chambers, and the crossclamp is released. The patient is rewarmed to 28 degrees. While rewarming, the superior ena cava is transected and oversewn at the cardiac end. The cranial end of the superior vena cava is anastomosed to the opening in the right pulmonary artery to create a superior cavopulmonary anastomosis.
The patient is fully rewarmed and weaned from cardiopulmonary bypass, The cannulas are removed and the sites secured. Chest tubes and temporary pacing wires are placed. Pericardial substitute membrane is placed to aid in future median sternotomies. The sternum is closed with wires, the abdominal fascia, skin and subcutaneous tissue closed in layers. Sterile dressing is applies and the patient is stabilized and transferred to the ICU.

Description of Post-Service Work: Accompany patient from operating room to intensive care unit. Discuss procedure outcome with family, and the referring physician. Coordinate care with other necessary physicians. Dictate operative report. Sign OR forms and write post-op orders for medications, labs, and nursing staff post operative care. Answer nursing and other staff questions. Visit patient during the posteoperative period as necessary to examine wounds and monitor patient progress and answer any of the family's questions. Write discharge orders for patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	John Mayer, MD				
Specialty(s):	STS/AATS				
CPT Code:	33622				
Sample Size:	100	**Resp N:**	20	**Response:** 20.0 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	2.00	30.00
Survey RVW:	42.00	60.00	**64.00**	65.50	80.00
Pre-Service Evaluation Time:			**90.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	240.00	300.00	**300.00**	360.00	540.00

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):	**345.00**	99231x **7.00** 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:	33622	**Recommended Physician Work RVU: 64.00**		
		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):	**345.00**	99231x **7.00** 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? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33783	090	65.08	**RUC Time**

CPT Descriptor Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); with reimplantation of 1 or both

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
61697	090	63.22	**RUC Time**	784

CPT Descriptor 1 Sugery of complex intracranial aneurysm, intracranial approach; carotid circulation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
33863	090	58.71	**RUC Time**	1,666

CPT Descriptor 2 Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis and coronary reconstruction

Other Reference CPT Code	Global	Work RVU	Time Source
33782	090	60.08	**RUC Time**

CPT Descriptor Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); without coronary ostium reimplantation

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

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 35.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 33622**	**Key Reference CPT Code: 33783**	**Source of Time RUC Time**
Median Pre-Service Time	63.00	63.00	
Median Intra-Service Time	300.00	360.00	
Median Immediate Post-service Time	60.00	60.00	
Median Critical Care Time	140.0	0.00	
Median Other Hospital Visit Time	345.0	0.00	
Median Discharge Day Management Time	38.0	0.00	
Median Office Visit Time	40.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**986.00**	**483.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.29	4.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.57	4.40
Urgency of medical decision making	3.43	3.40
Technical Skill/Physical Effort (Mean)		
Technical skill required	5.00	5.00
Physical effort required	5.00	5.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	5.00	5.00
Outcome depends on the skill and judgment of physician	4.86	4.80
Estimated risk of malpractice suit with poor outcome	3.71	3.40

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.71	4.40
Intra-Service intensity/complexity	5.00	5.00
Post-Service intensity/complexity	4.86	4.20

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 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) 33999 OR 33767, 33917, and 33619

How often do physicians 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? 90
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 90 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. Please explain the rationale for this estimate. This proceudre is a congenital cardiac procedure specific to the infant population

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? (ie. similar work RVU, and specialty) 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, 010, or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

33620 - Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)
33621 - Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)
33622 - Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)

Global Period: 090

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

An Expert Panel of Congenital Surgeons was used to develop the Practice Expense recommendations.

Please describe in detail the clinical activities of your staff:

The clinical labor activities are the same for each of the three procedures, 33620-33622

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.

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

The clinical staff will help coordinate the discharge of the patient from the hospital including coordination of home health services, post-operative monitoring, post-operative prescriptions, and assist with post-operative visits.

	A	B	C	D	E	F
1	**AMA/Specialty Society RVS Update Committee Recommendation**			33620	33621	33622
2	**Meeting Date: February 2010**	**CMS**	**Staff**	Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)	Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)	Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)
3	**LOCATION**	**Code**	**Type**	**Facility**	**Facility**	**Facility**
4	**GLOBAL PERIOD**					
5	**TOTAL CLINICAL LABOR TIME**	L051A	RN	**108.0**	**108.0**	**125.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L051A	RN	**60.0**	**60.0**	**60.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L051A	RN	**12.0**	**12.0**	**12.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**	L051A	RN	**36.0**	**36.0**	**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**	**5**
12	Coordinate pre-surgery services	L051A	RN	**20**	**20**	**20**
13	Schedule space and equipment in facility	L051A	RN	**8**	**8**	**8**
14	Provide pre-service education/obtain consent	L051A	RN	**20**	**20**	**20**
15	Follow-up phone calls & prescriptions	L051A	RN	**7**	**7**	**7**
16	Other Clinical Activity (please specify)					
17	**End: When patient enters office/facility for surgery/procedure**					
18	**SERVICE PERIOD**					
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**					
21	Greet Patient and Provide Gowning, Assure Appropriate Medical Records Are Available					
22	Obtain vital signs					
23	Provide pre-service education/obtain consent					
24	Prepare room, equipment, supplies					
[illegible]	Setup scope (non facility setting only)					
	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					
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					
38	Discharge day management	L051A	RN	**12**	**12**	**12**
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	99211 16 minutes		16			
47	99212 27 minutes		27			
48	99213 36 minutes		36	**1**	**1**	
49	99214 53 minutes		53			**1**
50	99215 63 minutes		63			
51	Other					
52	*Total Office Visit Time*			**36**	**36**	**53**
53	Other Activity (please specify)					
[illegible]	**End: with last office visit before end of global period**					
	MEDICAL SUPPLIES					
[illegible]	pack, minimum multi-specialty visit	SA048	pack	**1**	1	1
57	pack, post-op incision care (suture & staple)	SA053	pack	**1**	**1**	1
58	**Equipment**					
59	table, power	EF031		**36**	36	53
60	light, exam	EQ168		**36**	36	53

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2010

Ascending Aorta Repair

In October 2009, the CPT Editorial Panel deleted CPT code 33861 *Ascending aorta graft, with cardiopulmonary bypass, includes with or without valve suspension, when performed, includes coronary reconstruction, when performed; with coronary reconstruction* as the code is not commonly performed and contains overlap of physician work with the other procedures in the family. Editorial revisions were also made to CPT codes 33863 and 33864 for clarification only.

The RUC reviewed code 33861 and its family as part of the specialty societies' request to determine whether or not the new coding structure for reporting coronary reconstruction with ascending aorta repairs created by the deletion of 33861 necessitates budget neutrality adjustments. The specialties explained that the ascending aorta repair family of codes, 33860 *Ascending aorta graft, with cardiopulmonary bypass, includes with or without valve suspension, when performed,* (Work RVU = 59.46) and 33863 *Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with aortic root replacement using composite prosthesis valved conduit and coronary reconstruction (eg, Bentall)* (Work RVU = 58.79) were reviewed in August 2005 at the 3rd Five-Year Review and were revalued based on the Society of Thoracic Surgeons (STS) adult cardiac database. CPT code 33861 was not reviewed at the meeting due to a lack of data because the service has low Medicare utilization (255 instances billed in 2008). Entering the 3rd Five-Year Review, 33860 was valued at 37.94 RVUs and was increased to 59.33 RVUs after the RUC's review. However, 33861 was valued at 41.94 RVUs and not reviewed by the RUC. **Given that 33861 is the same service as the base code, 33860, with the additional work of the coronary reconstruction, the RUC agreed that this represented a rank order anomaly and should the RUC have valued the physician work of 33861 it would have been valued similar to the base code. The RUC also concurred that this family of codes should not need a budget neutrality reassessment.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲33860	L1	Ascending aorta graft, with cardiopulmonary bypass, includes ~~with or without~~ valve suspension, when performed	090	59.46 (No Change)
D 33861		~~with coronary reconstruction~~ (Code 33861 has been deleted. To report, see 33864)	090	N/A
▲33863	L2	Ascending aorta graft, with cardiopulmonary bypass, ~~with or without valve suspension~~; with aortic root replacement using ~~composite prosthesis~~ valved conduit and coronary reconstruction (eg, Bentall) (Do not report 33863 in conjunction with 33405, 33406, 33410, 33411, 33412, 33413, 33860) ~~(For graft of ascending aorta, with cardiopulmonary bypass and valve replacement, with or without coronary implant or valve suspension; use 33860 or 33861 and 33405 or 33406)~~	090	58.79 (No Change)
▲33864	L3	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic ~~annulus~~ root remodeling (eg, David Procedure, Yacoub Procedure) (Do not report 33864 in conjunction with ~~32551, 33210, 33211,~~ 33400, 33860-33863)	ZZZ	60.08 (No Change)

January 12, 2010

Barbara Levy, MD
Chair, American Medical Association, Relative Value Update Committee
515 N. State St.
Chicago, IL 60654

Re: Tab 9, Ascending Aorta Repair: The deletion of code 33861 and descriptor changes to codes 33860, 33863 and 33864

Dear Dr. Levy,

The Society of Thoracic Surgeons (STS) and the American Association for Thoracic Surgery would like to submit this letter for consideration by the RUC for Tab 9, Ascending Aorta Repair.

The STS/AATS requested that code 33861 - Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; with coronary reconstruction be deleted from the CPT coding manual. This code was considered by the RUC in August of 2000 as part of the 2nd 5-year review. The current Medicare frequency as of 2007 is 296 procedures/ year, which is a decline from 2007 when 313 procedures were preformed.

The requested descriptor changes to the other three codes were for anatomical correction and clarification purposes. The STS/AATS descriptor changes to these codes do not affect the work of the procedures performed. The e codes that were submitted for descriptor changes include the following codes and descriptor change requests:

33860 - Ascending aorta graft, with cardiopulmonary bypass, includes ~~with or without~~ valve suspension, when performed, includes coronary reconstruction, when performed;

33863 - Ascending aorta graft, with cardiopulmonary bypass, ~~with or without valve suspension~~; with aortic root replacement using ~~composite prosthesis~~ valved conduit and coronary reconstruction (eg, Bentall)

(Do not report 33863 in conjunction with 33405, 33406, 33410, 33411, 33412, 33413, 33860)

~~(For graft of ascending aorta, with cardiopulmonary bypass and valve replacement, with or without coronary implant or valve suspension; use 33860 or 33861 and 33405 or 33406)~~

33864 - Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic ~~annulus~~ root remodeling (eg, David Procedure, Yacoub Procedure)

(Do not report 33864 in conjunction with ~~32551, 33210, 33211,~~ 33400, 33860-33863)

With the deletion of code 33861, CPT will redirect the coding for the procedure to code 33860 with the following parenthetical note:

(Code 33861 has been deleted. To report, see 33860)

The current status of all the codes as far as review dates, RVW and Medicare frequency are as follows:

Code	RUC Review Date	Current 2010 RVW	2008 Medicare Frequency
33860	August, 2005 (3rd 5-year review)	59.46	2,978
33861	August 2000 (2nd 5-year review)	44.07	296
33863	August, 2005 (3rd 5-year review)	58.79	1,666
33864	New Code April 2007	60.08	No data in RUC database

With the request to delete code 33861, it is being re-directed to a higher valued code, 33860. The STS/AATS consider code 33861 as a rank order anomaly within this family of codes since it represents a procedure with more work than the work that is currently described by code 33860. The codes are the same with the additional work of the coronary reconstruction being performed in addition to work described in code 33860. The decision to delete code 33861 by the STS/AATS was based on the low frequency, that this procedure is not as commonly done, and the overlap of the work with the other procedures in the family, making code 33861 a redundant code. The deletion of the code cleans up the family of codes. If the STS/AATS had not decided to request deletion of this code, the Societies would have included it in the upcoming 4th 5-year review for consideration for review. It was not included in the 3rd 5-year review because the Adult Cardiac STS database did not have any specific data on this procedure.

Based on these issues, the STS/AATS feel that any budget neutrality adjustments applied to code 33860 (or the family of codes) based on the deletion of code 33861 take into consideration that code 33861 is clearly a rank order anomaly within this family of codes.

Sincerely,

Jim Levett, MD
STS/AATS RUC Advisor

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2010

Sentinel Lymph Node Mapping

The CPT Editorial Panel created a new add-on code to report sentinel lymph node mapping technique which has become the standard of care for initial regional lymph node assessment, replacing complete regional lymph node dissection for most patients. Analysis of regional lymph nodes in breast cancer is the single most important prognostic factor and is essential in determining the appropriate adjuvant treatment. CPT code 38792 *Injection procedure; for identification of sentinel node,* only describes injection of dye. There is no current code to describe the work related to mapping, after dye is injected. New code 38900 represents a new surgical technique that has develeoped over the past 5-10 years. This technique, when performed, requires additional physician work compared with simple dissection of palpable nodes.

119

The RUC reviewed the survey data for 38900 *Intraoperative sentinel lymph node(s) identification (eg, mapping), includes injection of non-radioactive dye, when performed* and agreed that the recommended service times were appropriate including the additional 2 minutes of pre-service time for the physician to review the risks with the patient including lymphedema, numbness and pain as the search for the sentinel node means additional dissection. The RUC compared the surveyed code to key reference code 19126 *Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker* (Work RVU=2.93). The RUC noted that although 38900 required more mental effort and judgment to perform as compared to the reference code, 19126 had more intra-service time, 60 minutes and 45 minutes, respectively. Based on this comparison, the RUC agreed with the specialty society that 2.50 work RVUs, the survey's 25th percentile, accurately reflects the relative physician work being performed. **The RUC recommends 2.50 Work RVUs for 38900.**

New Technology
As the technique to perform this service is new, and to ensure that the utilization estimates provided by the specialty are accurate, **the RUC recommends that 38900 be added to the New Technology/Service List.**

Further, the RUC recommends that a CPT Assistant Article be written to accurately describe how this service is reported with other services.

Practice Expense: The RUC reviewed and agreed with the specialty recommendation for no direct practice expense inputs for these services as this service is an add-on in the facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●+38900	AA1	Intraoperative sentinel lymph node(s) identification (eg, mapping), includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure) (Use 38900 in conjunction with 19302, 19307, 38500, 38510, 38520, 38525, 38530, 38542, 38740, 38745) (For injection of radioactive tracer for identification of sentinel node, use 38792)	ZZZ	2.50

120

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:38900 Tracking Number AA1 Specialty Society Recommended RVU: **2.50**

Global Period: ZZZ RUC Recommended RVU: **2.50**

CPT Descriptor: Intraoperative sentinel lymph node(s) identification (eg, mapping), includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old female was recently diagnosed with cancer of the right breast utilizing a percutaneous needle biopsy technique. She undergoes right axillary sentinel node biopsy at the time of her definitive surgical procedure for breast cancer (partial mastectomy or mastectomy). [Note: 38900 is an add-on code that only includes the additional work for sentinel node mapping, including injection of non-radioactive dye, when performed. Work related to a definitive procedure, when performed, would be reported separately.]

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

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

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

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work: Additional work includes review the additional risks (lymphedema, numbness, pain) as the search for the sentinel node means additional dissection, more than would normally be required for a lymph node biopsy alone. There is additional discussion related to the risk of allergy if isosulfan blue is used. There is additional coordination with the anesthesiologist related to the injection, especially if there is any hypotension with induction.

Description of Intra-Service Work: The patient undergoes injection of a radiotracer prior to entering the operative suite (reported separately). After induction of moderate or general anesthesia, non-radioactive blue dye, when utilized, is injected and the breast is massaged for five to ten minutes to ensure migration of the dye to the axilla. Background and injection bed counts are obtained. The gamma probe is then used to identify: 1) the site of the sentinel node(s) within the axilla; 2) the presence of non-axillary sentinel node(s), with particular attention to internal mammary and/or supraclavicular node(s); and/or 3) the presence of intramammary sentinel node(s).

Following the axillary skin incision and soft tissue dissection (included in work of the definitive procedure), the axillary contents, both superficial and deep levels, are examined, looking for blue sentinel nodes and/or afferent lymphatics leading

to sentinel nodes, if non-radioactive blue dye has been injected. Additionally, if blue dye is utilized, afferent lymphatics may be visualized superficially, necessitating dissection along the lymphatic channels deep into the axilla. Care is taken not to disturb the afferent lymphatics, thereby allowing continued drainage of the isotope and/or dye to the sentinel nodes, and avoiding spillage of tracer into the operative field. The gamma probe is used concurrently to detect radioactivity in any axillary node(s).

Sentinel node(s) is(are) identified by the presence of increased isotope counts and/or visible blue dye and/or a blue afferent lymphatic. Once a sentinel node is identified, afferent and efferent lymphatic channels are ligated to ensure no spillage of radiotracer or blue dye. Ten-second ex-vivo isotope counts are taken from "hot" sentinel node(s), and the dissection bed is queried with the probe to verify applicable radioactive node(s) have been removed. It is particularly important to remove the "hottest" sentinel node and all nodes with isotope counts which are at least 10% of those in the "hottest" sentinel node. As individual nodes are identified, they are submitted to pathology for intraoperative analysis by frozen section or touch prep. Pathology verifies the presence or absence of malignant cells sequentially in each node submitted and communicates this information to the operating surgeon. Confirmation of malignant cells within any node may direct further lymphadenectomy as indicated. Typically, three sentinel nodes are removed per patient, with a range of one to five. The lymph node(s) is(are) submitted to pathology as individual specimens requiring all lymph node clusters to be dissected ex vivo and separated labeled and submitted.

After the removal of "hot" and/or blue sentinel node(s), the axilla is carefully palpated, and any node(s) which is(are) palpably suspicious is(are) removed and also submitted as sentinel node(s). If sentinel node(s) is(are) identified at a non-axillary sites, these are also removed (included in work of a definitive procedure). If intraoperative pathologic evaluation of the sentinel lymph node(s) is(are) negative for malignancy, the procedure is terminated and incisions are closed as indicated by the definitive procedure.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Eric Whitacre, MD, FACS; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS;				
pecialty(s):	general surgery, breast surgery, surgical oncology				
CPT Code:	38900				
Sample Size:	2000	**Resp N:**	231	**Response:** 11.5 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	30.00	**60.00**	100.00	750.00
Survey RVW:	1.00	2.50	**3.00**	3.50	5.00
Pre-Service Evaluation Time:			**2.00**		
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	100.00

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**
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: ZZZ Global Code

CPT Code:	38900	**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:		**2.00**	**0.00**	**2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
`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? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
19126	ZZZ	2.93	**RUC Time**

CPT Descriptor Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker (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
60512	ZZZ	4.44	**RUC Time**	

CPT Descriptor 1 Parathyroid autotransplantation (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: 118 **% of respondents:** 51.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 38900**	**Key Reference CPT Code: 19126**	**Source of Time RUC Time**
Median Pre-Service Time	2.00	0.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**47.00**	**60.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.44	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.43
Urgency of medical decision making	3.42	3.19
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.90	3.48
Physical effort required	2.98	2.89
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.24	2.85
Outcome depends on the skill and judgment of physician	4.18	3.78
Estimated risk of malpractice suit with poor outcome	3.70	3.55

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.18	3.11
Intra-Service intensity/complexity	3.85	3.54
Post-Service intensity/complexity	2.73	2.58

Additional Rationale and Comments

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 Recommendations for the appropriate formula and format.*

Analysis of regional lymph nodes in breast cancer (and other less common malignancies such as melanoma) is the single most important prognostic factor and is essential to determination of appropriate adjuvant treatment. Sentinel

lymph node analysis has become the standard of care for initial regional lymph node assessment, replacing complete regional lymph node dissection for most patients. Codes exist for lymph node biopsy and complete regional dissection, but not for the sentinel node mapping technique. The CPT Editorial Panel recently approved a new code for correct reporting of this technique.

The American College of Surgeons and the American Society of Breast Surgeons conducted a RUC survey and received 231 responses. An expert panel of general surgeons and surgeons specializing in breast and oncology reviewed the survey data and agree that the median intra-operative time of 45 minutes is an accurate reflection of the time to perform sentinel lymph node mapping, which includes intra-operative injection of non-radioactive blue dye and identification and excision of sentinel nodes for pathology analyses prior to completion of a definitive procedure (eg, partial mastectomy or mastectomy). Typically three sentinel nodes are excised, with a range of one to six.

We are recommending 3.00 work RVUs (median). This value results in an IWPUT of 0.066, which is low for an open add-on procedure. However, for this procedure, the lower intensity is acceptable as it accounts for some waiting time for pathology results.

There is no code that captures the work of sentinel node mapping, which is very different from lymph node excisional biopsy alone, and also different from the extirpative lymphadenectomy codes. Lymph node excision is usually performed for a palpable node, and less frequently for a radiographically abnormal node to establish a diagnosis that cannot be made by needle biopsy alone (eg, lymphoma). The node, or cluster of adjacent nodes are identified and frequently "shelled out" by gentle blunt dissection. There is not a need to identify a specific node – any abnormal appearing node is generally adequate – and no attempt is made to identify afferent lymphatics. Adjacent structures are protected from injury though limited gentle blunt dissection.

In contrast, sentinel lymph node mapping and dissection depends entirely on the accurate identification of specific lymph nodes containing blue dye and/or radiotracer, or even by the presence of blue stained afferent lymphatics (sentinel lymph nodes are defined as nodes which are radioactive, are blue stained, have afferent blue stained lymph even when the node is not blue, as well as grossly abnormal lymph nodes identified during the surgical procedure.) A blue stained or radioactive sentinel node may be immediately adjacent to a nonsentinel lymph node and the procedure requires dissection of the specific sentinel node, and preferably not the 2 together, as the sentinel node is separately and more thoroughly analyzed by the pathologist with additional sections and stains. This is fundamental to the sentinel lymph node concept, which is a more precise and detailed evaluation of regional lymph node involvement. This is clearly a surgical procedure distinct from the existing lymph node biopsy and regional dissection codes, as confirmed by extensive literature documenting a "learning curve" for surgeons already proficient with standard operative techniques.

The work of sentinel node mapping and node excision has previously been reported with code 38740 *Axillary lymphadenectomy; superficial* plus 38792 *Injection procedure; for identification of sentinel node* (RVW= 10.70+0.26= 10.96).

This was not the most precise coding to describe the work of sentinel node mapping and excision of sentinel nodes. The work will now accurately be reported with as 38500 *Biopsy or excision of lymph node(s); open, superficial* (RVW=3.79) OR 38525 *Biopsy or excision of lymph node(s); open, deep axillary node(s)* plus 38900 [RVW= (3.79 or 6.43)+3.00= 6.79 or 9.32]. The selection of 38500 or 38525 will depend on the location of the deepest LN. Further, the new code 38900 now includes the blue dye injection and code 38792 will be edited to clearly indicate it is only for injection of radioactive tracer.

SERVICES REPORTED WITH MULTIPLE 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 code will be reported with 38500 Biopsy or excision of lymph node(s); open, superficial (RVW=3.79) OR 38525 Biopsy or excision of lymph node(s); open, deep axillary node(s) plus 389XX [RVW= (3.79 or 6.43)+3.00= 6.79 or 9.32]. The selection of 38500 or 38525 will depend on the location of the deepest LN.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 19302, 19307, 38500, 38510, 38520, 38525, 38530, 38542, 38740, 38745 all with modifier -22

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

Specialty general surgery How often? Commonly

Specialty surgical oncology How often? Commonly

Specialty How often?

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

Specialty Frequency Percentage %

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?
20,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This estimate is equal to approximately 50% of 38792 (Injection procedure; for identification of sentinel node) to account for estimated reporting of non-radioactive dye.

Specialty general surgery Frequency 12000 Percentage 57.83 %

Specialty surgical oncology Frequency 8000 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? (ie. similar work RVU, and specialty) 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
Direct Inputs

CPT Long Descriptor:

38900 Intraoperative sentinel lymph node(s) identification (eg, mapping), includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)

FACILITY ONLY

NO CLINICAL STAFF, SUPPLIES, OR EQUIPMENT

AMA/Specialty Society RVS Update RUC
Summary of Recommendations

April 2010

Paraesophageal Hernia Procedures

In February 2010, the CPT Editorial Panel deleted six existing codes and created ten new codes to remove obsolete and duplicative codes and add new codes to report current surgical techniques for paraesophageal hernia repair.

The specialty societies indicated and the RUC agreed that there is compelling evidence that technology has changed the physician work to repair esophageal hernias. When the original paraesophageal hernia repair codes were introduced, they were meant to report anatomic defects within the diaphragm. Thus for many years, paraesophageal hernias were repaired by simply reducing the hernia contents below the diaphragm and narrowing the diaphragmatic crura with sutures to prevent re-herniation. These repairs were performed in an open fashion by either a transabdominal or transthoracic approach. Sometimes tacking sutures were used to fix the stomach to the abdominal wall or occasionally a gastrostomy tube was placed to fix the stomach in place so it would not re-herniate. Occasionally, strictures were dilated or concomitant ulcer disease was treated by vagotomy and pyloroplasty.

133

Because this was the era prior to modern anti-acid treatment with H2 histamine blockers and PPIs, esophageal strictures requiring treatment were frequent occurrences in paraesophageal hernia patients. In addition, ulcer disease of the stomach and duodenum was also commonly treated because H. pylori had not yet been recognized as an etiologic agent. It was therefore frequent to find giant paraesophageal hernias associated with concomitant strictures and/or ulcer disease. For these reasons, the diaphragmatic hernia repair codes were written to include concomitant treatment for strictures (with and without dilation) and ulcer disease (with or without vagotomy and pyloroplasty). However, in 2010, these treatments (dilation, V&P) are virtually never performed concomitant with paraesophageal hernia repair, and thus the codes as written do not reflect current therapy.

Modern investigation has emphasized the importance of the lower esophageal sphincter's ability to generate pressure to prevent gastroesophageal reflux and the need to augment sphincter pressure with fundoplication, typically a 360 degree full wrap (Nissen) or a partial wrap (Belsey, Mark IV, Toupet). With this further understanding of the pathophysiology, these defects have now been reclassified as variants of hiatal hernia. The current coding schema is in direct opposition to this modern classification. The adjunctive surgical procedures of intraoperative dilatation, vagotomy, and pyloroplasty are now virtually never concomitantly performed with paraesophageal hernia repair; however, fundoplasty is almost always performed. Esophageal dilatation, if needed, is now done by gastroenterologists before any surgical procedure.

In summary, the work described by the current (to-be-deleted) codes was intended for patients with acid reflux (chemical symptoms) or blockage (mechanical symptoms). With the advent of medical management and less invasive treatments, the patients currently undergoing surgery are symptomatic, typically with blockage. The typical patient has more advanced disease and requires more complex repair.

BB1 - 43327 *Esophagogastric fundoplasty partial or complete; laparotomy*
The RUC reviewed survey results from 64 cardiothoracic and general surgeons for code 43327 and compared it to key reference service 43280 *Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)* (work RVU = 18.10 and 150 minutes intra-service time). The RUC determined that 43327 required comparable mental effort, technical skill and psychological stress to perform as key reference service 43280 and therefore recommends the same work RVU of 18.10. The RUC determined that the survey physician time of 63 minutes pre-service, 120 minutes intra-service, and 30 minutes immediate post-service time appropriately accounts for the time required to perform this service. For additional support, the RUC compared 43327 to similar service 38100 *Splenectomy; total* (work RVU = 19.55), which requires the same intra-service time (120 minutes) to perform as 43327, minus two 99231 hospital visits associated with 38100 (19.55 - 1.42 = 18.13), which results in a work RVU of 18.13. **The RUC recommends a work RVU of 18.10 for code 43327.**

BB2 – 43328 *Esophagogastric fundoplasty partial or complete; thoracotomy*
The RUC reviewed the survey results from 47 cardiothoracic and general surgeons for code 43328. The specialty societies selected and modified pre-service package 4 – Facility-Difficult Patient/Difficult Procedure, adding 17 minutes positioning time to account for placing the patient in the lateral decubitus position with specific attention to padding to protect the nerves throughout the procedure. The RUC agreed that the additional pre-service positioning time is appropriate to position the patient. The RUC reviewed the surveyed intra-service time of 150 minutes for 43328 compared to the key reference service 43282 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh* (work RVU = 30.10 and 210 minutes intra-service time). The RUC determined that 43328 required more mental effort, technical still and was more intense and complex than 43282, however, required less physician time to perform. The RUC also compared the thoracic approach to the laparoscopic approach (43327) and determined that 43328 would require more intra-service time. Therefore, 150 minutes intra-service time and a work RVU of 27.00, the survey median, for 43328 appropriately places this service in proper rank order. **The RUC recommends the survey median work RVU of 27.00 for code 43328.**

BB3 – 43332 *Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis*

The RUC reviewed the survey results from 64 cardiothoracic and general surgeons for code 43332 and compared it to key reference code 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* (work RVU = 26.60). The specialty society indicated and the RUC agreed that the open abdominal approach 43332, would require less intra-service time than the laparoscopic approach, 43281, 150 minutes and 180 minutes, respectively, but more post-service work. Additionally, the mental effort and technical skill required to perform these services are comparable. The RUC agreed that total physician work was the same for 43332 and 43281. **The RUC recommends the survey median work RVU of 26.60 for code 43332.**

BB4 – 43333 *Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis*

The RUC reviewed the survey results from 63 cardiothoracic and general surgeons for 43333 and compared it to key reference service 43282 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh* (work RVU = 30.10 and 210 minutes intra-service time) and determined it required similar mental effort, technical skill and psychological stress to perform. The RUC determined that the survey physician time of 63 minutes pre-service, 180 minutes intra-service, and 30 minutes immediate post-service time appropriately account for the time required to perform this service.. The RUC agreed that the survey median work RVU of 30.00 appropriately accounted of the physician work required to perform 43333. The RUC compared 43333 to the "without mesh" code 43332 *Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis* and determined that the incremental difference 3.40 work RVUs (30.00 – 26.60 = 3.40) for implantation of mesh was appropriate and would maintain correct rank order.

The RUC compared the "with" and "without mesh" paraesophageal laparotomy codes 43332 and 43333 to "with" and "without mesh" paraesophageal laparoscopic codes 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mes*h (work RVU = 26.60 and 180 minutes intra-service time) and 43282 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh* (work RVU = 30.10 and 210 minutes intra-service time) which accounts for an incremental difference of 3.50 work RVUs for the implantation of mesh. Additionally, the RUC compared the incremental work related to mesh for 43333 to 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, ZZZ global period). Based on these comparisons, the RUC determined that the implantation of mesh incremental difference of 3.40 for 43332 and 43333 is appropriate. **The RUC recommends the survey median work RVU of 30.00 for code 43333.**

BB5 – 43334 ***Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis***

The RUC reviewed the survey results from 46 cardiothoracic and general surgeons for code 43334. The specialty societies selected and modified pre-service package 4 – Facility-Difficult Patient/Difficult Procedure, adding 17 minutes positioning time to account for placing the patient in the lateral decubitus position with specific attention to padding to protect the nerves throughout the procedure. The RUC agreed that the additional pre-service positioning time is appropriate to position the patient. The RUC compared 43334 to key reference code 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* (work RVU = 26.60 and 180 minutes intra-service time) and determined that the physician intra-service time required to perform these services are the same. However, the RUC agreed that the transthoracic approach for 43334 is more intense and complex, requires greater post-operative care (two additional hospital visits) and requires slightly more pre-service time (10 additional minutes) than 43281 and therefore should be valued higher than 43281 to maintain appropriate rank order. **The RUC recommends the survey median work RVU of 30.00 for code 43334.**

BB6 43335 ***Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis***

The RUC reviewed the survey results from 47 cardiothoracic and general surgeons for code 43335. The specialty societies selected and modified pre-service package 4 – Facility-Difficult Patient/Difficult Procedure, adding 17 minutes positioning time to account for placing the patient in the lateral decubitus position with specific attention to padding to protect the nerves throughout the procedure. The RUC agreed that the additional pre-service positioning time is appropriate to position the patient. The RUC compared 43335 to the key reference code 43282 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh* (work RVU = 30.10) and determined that the physician intra-service time required to perform 43335 is slightly less than 43282, 200 minutes and 210 minutes, respectively. However, the RUC agreed that the transthoracic approach for 43335 is more intense and complex, requires greater post-operative care (two additional hospital visits) and requires slightly more pre-service time (10 additional minutes) than 43282. Additionally, the RUC reviewed the intra-service time for without mesh code 43334 and determined that 20 additional minutes for intra-service time and 3.00 more work RVUs for the "with mesh" code 43335 appropriately place these services in the proper rank order. **The RUC recommends the survey median work RVU of 33.00 for code 43335.**

BB7 – 43336 ***Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis***

The RUC reviewed the survey results from 39 cardiothoracic and general surgeons for code 43336. The specialty societies selected and modified pre-service package 4 – Facility-Difficult Patient/Difficult Procedure, adding 17 minutes positioning time to account for placing the patient in the lateral decubitus position with specific attention to padding to protect the nerves throughout the procedure. The RUC agreed that the additional pre-service positioning time is appropriate to position the patient. The RUC compared 43336 to

the key reference code 43632 *Gastrectomy, partial, distal; with gastrojejunostomy* (work RVU = 35.14 and 225 minutes intra-service time) and determined that 43336 required comparable physician time (240 minutes intra-service time), intensity and complexity to perform. **The RUC recommends the survey median work RVU of 35.00 for code 43336.**

BB8 – 43337 *Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis*
The RUC reviewed the survey results from 39 cardiothoracic and general surgeons for code 43337. The specialty societies selected and modified pre-service package 4 – Facility-Difficult Patient/Difficult Procedure, adding 17 minutes positioning time to account for placing the patient in the lateral decubitus position with specific attention to padding to protect the nerves throughout the procedure. The RUC agreed that the additional pre-service positioning time is appropriate to position the patient. The RUC also compared 43337 to the key reference code 43632 *Gastrectomy, partial, distal; with gastrojejunostomy* (work RVU = 35.14 and 225 minutes intra-service time) and determined that 43337 required more physician time (260 minutes intra-service time), intensity and complexity to perform. Additionally, the RUC reviewed the intra-service time for "without mesh" code 43336 and determined that 20 additional minutes for intra-service time and 2.50 more work RVUs (as indicated by those physicians performing this service in the last year) for "with mesh" code 43337 appropriately place these services in the proper rank order. **The RUC recommends the survey median work RVU of 37.50 for code 43337.**

137

BB9 – 43338 *Esophageal lengthening procedure (eg Collis gastroplasty or wedge gastroplasty)*
The RUC reviewed the survey results from 43 cardiothoracic and general surgeons for code 43338 compared to key reference code 44121 *Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)* (work RVU = 4.44 and 60 minutes intra-service time) and agreed with the specialty society that the survey median work RVU of 5.00 and 25th percentile work RVU of 4.50 were too high, as the key reference service requires twice the physician time compared to 43338, 60 minutes versus 30 minutes respectively. However, 43338 requires more mental effort and judgment, technical skill/physical effort and psychological stress than 44121. The specialty society indicated and the RUC agreed that 3.00 work RVUs results in an intensity which is consistent with the intensity of the primary procedures in this family and consistent with other ZZZ add-on MPC codes (22525, 35600, 60512, 63295). **The RUC recommends the survey low response work RVU of 3.00 for code 43338.**

BB10 – 43283 *Laparoscopy, surgical, esophageal lengthening procedure (eg Collis gastroplasty or wedge gastroplasty)*
The RUC reviewed the survey results from 43 cardiothoracic and general surgeons for code 43283 compared them to key reference code 44121 *Enterectomy, resection of small intestine; each additional resection and anastomosis* (work RVU = 4.44 and 60 minutes intra-service time) and agreed with the specialty society that the survey 25th percentile work RVU of 4.80 was too high, as the key reference service requires more physician time to perform than 43283, 60 minutes versus 40 minutes respectively. The specialty

society indicated and the RUC agreed that 4.00 work RVUs results in an intensity which is consistent with the intensity of the primary procedures in this family and consistent with other ZZZ add-on MPC codes (22525, 35600, 60512, 63295). For further support the RUC also compared 43283 to similar service, 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof* (work RVU = 3.73 and 40 minutes intra-service time). **The RUC recommends a work RVU of 4.00 for code 43283.**

Practice Expense

The RUC reviewed and recommend the standard 090 global direct practice expense inputs for CPT codes 43327 – 43338 performed only in the facility setting. In addition, the RUC recommends no direct practice expense inputs for add-on codes 43338 and 43283.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 39502		~~Repair, paraesophageal hiatus hernia, transabdominal, with or without fundoplasty, vagotomy, and/or pyloroplasty, except neonatal~~ (39502 has been deleted. To report transabdominal paraesophageal hiatal hernia repair with fundoplasty, vagotomy, and/or pyloroplasty when performed, see 43332, 43333)	090	N/A
D 39520		~~Repair, diaphragmatic hernia (esophageal hiatal); transthoracic~~ (39520 has been deleted. To report transthoracic diaphragmatic [esophageal hiatal] hernia repair, see 43334, 43335)	090	N/A
D 39530		~~Repair, diaphragmatic hernia (esophageal hiatal); combined, thoracoabdominal~~ (39530 has been deleted. To report thoracoabdominal diaphragmatic [esophageal hiatal] hernia repair, see 43336, 43337)	090	N/A
D 39531		~~Repair, diaphragmatic hernia (esophageal hiatal); combined, thoracoabdominal, with dilation of stricture (with or without gastroplasty)~~	090	N/A

CPT Code (•New)	Track-ing Num-ber	CPT Descriptor	Global Period	Work RVU Recommendation
		(39531 has been deleted. To report thoracoabdominal diaphragmatic [esophageal hiatal] hernia repair, see 43336, 43337)		
D 43324		~~Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures)~~ (43324 has been deleted. To report Esophagogastric fundoplasty see 43327 or 43328)	090	N/A
D 43326		~~Esophagogastric fundoplasty; with gastroplasty (eg, Collis)~~ (43326 has been deleted. To report esophagogastric fundoplasty with gastroplasty, see 43327, 43328, 43332, 43334, 43336, 43338)	090	N/A
•43327	BB1	Esophagogastric fundoplasty partial or complete; laparotomy	090	18.10
•43328	BB2	Esophagogastric fundoplasty partial or complete; thoracotomy	090	27.00
•43332	BB3	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis	090	26.60
•43333	BB4	with implantation of mesh or other prosthesis (For neonatal diaphragmatic hernia repair, use 39503)	090	30.00
•43334	BB5	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis	090	30.00
•43335	BB6	with implantation of mesh or other prosthesis (For neonatal diaphragmatic hernia repair, use 39503)	090	33.00
•43336	BB7	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis	090	35.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●43337	BB8	with implantation of mesh or other prosthesis (For neonatal diaphragmatic hernia repair, use 39503)	090	37.50
●+43338	BB9	Esophageal lengthening procedure (eg Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary service) (Report 43338 in conjunction with 43327 – 43337)	ZZZ	3.00
●+43283	BB10	Laparoscopy, surgical, esophageal lengthening procedure (eg Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure) (Report 43283 in conjunction with 43280, 43281, 43282)	ZZZ	4.00

140

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43327 Tracking Number BB1 Specialty Society Recommended RVU: **20.00**

Global Period: 090 RUC Recommended RVU: **18.10**

CPT Descriptor: Esophagogastric fundoplasty partial or complete; laparotomy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52-year-old female has a sliding hiatus hernia and severe reflux, dysphagia and postprandial pain. The symptoms are unresponsive to medication and the patient is referred for surgical repair.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Moderate Sedation

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

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

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

Description of Pre-Service Work: 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. Review results of preadmission labs and imaging. 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 draped. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A midline laparotomy is made and the left lobe of the liver is mobilized to expose the hiatus. Any adhesions between the liver, stomach, and crura are meticulously taken down. The gastroesophageal junction is dissected circumferentially and adhesions between the posterior fundus and the crural are taken down creating a generous retroesophageal window. The Hiatal hernia is reduced to bring down the gastroesophageal junction to an intraabdominal position for at least 3 cm. The crura are opened to allow for a generous circumferential intrathoracic mobilization of the distal esophagus. If the gastroesophageal junction cannot be easily reduced 3 cm below the hiatus a lengthening procedure is performed (reported separately). A 56 French esophageal dilator is advanced into the esophagus by the anesthesiologist so that it can be used to appropriately "size" the crural repair and fundoplication. The crural pillars are then apposed with 1 to 3 sutures posteriorly to narrow the hiatus. The posterior fundic wall is brought through the retroesophageal window so

that it lies to the right of the esophagus. The fundoplication is then reconstructed by bringing the anterior fundus over the top of the gastroesophageal junction and sewing it to the posterior fundus with three sutures. Next either a total or partial wrap is constructed. This relocates the gastric wrap to its appropriate position. The dilator is removed, hemostasis is obtained, and the peritoneal cavity is irrigated with saline. The midline laparotomy incision is then closed.

Description of Post-Service Work:
Hospital: Apply sterile dressings. Monitor patient during reversal of anesthesia. Avoidance of sudden straining during extubation is stressed. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia and anti-emetics. 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 ICU and discuss ongoing care with floor nurses. Order x-rays as per routine. Examine patient, including reviewing vital signs and respiratory status. 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 (eg. 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 wi[redacted] referring physician(s) (verbal and written). Dictate progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010		
Presenter(s):	Keith Naunheim, MD, FACS; Francis Nichols, MD, FACS; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS		
Specialty(s):	cardiothoracic surgery; general surgery		
CPT Code:	43327		
Sample Size:	600	**Resp N:** 64	**Response:** 10.6 %
Sample Type:	Random	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	4.00	20.00
Survey RVW:	16.00	19.00	**20.00**	23.25	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:	90.00	90.00	**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):	**115.00**	99231x **1.00** 99232x **1.00** 99233x **1.00**
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:	43327	**Recommended Physician Work RVU: 20.00**		
		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:		**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):	**115.00**	99231x **1.00** 99232x **1.00** 99233x **1.00**
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? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43280	090	18.10	**RUC Time**

CPT Descriptor Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
38100	090	19.55	**RUC Time**	3,128

CPT Descriptor 1 Splenectomy; total (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
44140		22.59	**RUC Time**	30,614

CPT Descriptor 2 Colectomy, partial; with anastomosis

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:** 46.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 43327**	**Key Reference CPT Code:** 43280	**Source of Time** **RUC Time**
Median Pre-Service Time	63.00	100.00	
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	115.0	40.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	46.0	46.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**412.00**	**404.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.93	2.97
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	3.28
Urgency of medical decision making	2.27	2.31
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.27	3.55
Physical effort required	3.13	3.24
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.93	3.00
Outcome depends on the skill and judgment of physician	3.67	3.79
Estimated risk of malpractice suit with poor outcome	3.27	3.28

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.97	3.00
Intra-Service intensity/complexity	2.97	3.17
Post-Service intensity/complexity	2.70	2.79

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.*

Compelling Evidence

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

The change in the work to repair an esophageal hernia over time has resulted in confusion and deficiencies in the coding structure necessitating a revision of the current CPT codes. When the original paraesophageal hernia repair codes were introduced, they were meant to report anatomic defects within the diaphragm. Dr. Allison originated these repairs and emphasized the importance of the diaphragm in the pathophysiology of hiatus hernias (Allison PR, Ann Surg 1973;178:273-6). Thus for many years (in the now distant past), paraesophageal hernias were repaired by simply reducir the hernia contents below the diaphragm and narrowing the diaphragmatic crura with suture to prevent re-herniation. These repairs were performed in an open fashion by either a transabdominal or transthoracic approach. Sometimes tacking sutures were used to fix the stomach to the abdominal wall or occasionally a gastrostomy tube was placed to fix the stomach in place so it would not re-herniate. Occasionally, strictures were dilated or concomitant ulcer disease was treated by vagotomy and pyloroplasty.

Because this was the era prior to modern anti-acid treatment with H2 histamine blockers and PPIs, esophageal strictures requiring treatment were frequent occurrences in paraesophageal hernia patients. In addition, ulcer disease of the stomach and duodenum was also common at that time because H. pylori had not yet been recognized as an etiologic agent. It was therefore frequent to find giant paraesophageal hernias associated with concomitant strictures and/or ulcer disease. For these reasons, the diaphragmatic hernia repair codes were written to include concomitant treatment for strictures (with and without dilation) and ulcer disease (with or without vagotomy and pyloroplasty). However, in 2010, these treatments (dilation, V&P) are virtually never performed concomitant with paraesophageal hernia repair, and thus the codes as written do not reflect current therapy.

Modern investigation has emphasized the importance of the lower esophageal sphincter's ability to generate pressure to prevent gastroesophageal reflux and the need to augment sphincter pressure with fundoplication, typically a 360 degree full wrap (Nissen) or a partial wrap (Belsey, Mark IV, Toupet). With this further understanding of the pathophysiology, these defects have now been reclassified as variants of hiatal hernia. The current coding schema is in direct opposition to this modern classification. The adjunctive surgical procedures of intraoperative dilatation, vagotomy, and pyloroplasty are now virtually never concomitantly performed with paraesophageal hernia repair; however, fundoplasty is almost always performed. Esophageal dilatation, if needed, is now done by gastroenterologists before any surgical procedure.

In summary, the work described by the current (to-be-deleted) codes was intended for patients with reflux/acid (chemical symptoms) or blockage (mechanical symptoms). With the advent of medical management and less invasive treatments, the patients currently undergoing surgery are symptomatic, typically with blockage. The typical patient has more advanced disease and requires more complex repair.

Recommendation – BB1 (43327) and BB2 (43328)
The Society of Thoracic Surgeons and the American College of Surgeons conducted a RUC survey and received 64 responses for BB1 and 47 responses for BB2. A consensus panel of cardiothoracic surgeons and general surgeons reviewed the survey data and agree that the median intra-operative time of 120 minutes is an accurate reflection of the time to perform BB1. This is the same intra-time from the previous survey of general surgeons and reflective of intra-time required for the abdominal approach to perform a Nissen. The panel also agrees that the thoracic approach would take longer and agree with the 150 minutes of intra-time for BB2. With respect to post-op hospital visits, the panel notes that the patients (both BB1 and BB2) would be transferred to the ICU post-operatively. Although the patient is unstable and requires ICU attention, the surgeon would not typically provide critical care for more than 30 minutes per day and so we have chosen level three post-op hospital visit(s) to account for the ICU care.

While the panel believes that the current RVWs for 43324 are relatively accurate for the abdominal Nissen, we are recommending an RVW of 18.10 for BB1 (which is less than the current value) and survey median RVW of 27.00 for BB2, the thoracic Nissen. These recommendations result in total RVUs that are less than work neutral for theses codes.

Pre-time package 4 (difficult patient/difficult) procedure is appropriate for BB1 and BB2. Additional time was added to BB2 for positioning; patient is placed in lateral decubitus position with attention to padding to protect the nerves for the lengthy 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) 43324 (or 43326 if a gastroplasty was also performed)

How often do 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 thoracic surgery	How often? Rarely
Specialty cardiac surgery	How often? Rarely
Specialty general surgery	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. Not able to estimate national frequency

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,206
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. BB1 was previously reported with 43324 (or 43326 if a gastroplasty was also performed). A review of the frequency for all deleted codes and croswalking to new codes resulted in an estimate of (80% x frequency of 43324) plus (40% frequency of 43326).

pecialty general surgery	Frequency 1146	Percentage 95.02 %
Specialty cardiothoracic surgery	Frequency 60	Percentage 4.97 %
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? (ie. similar work RVU, and specialty) 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:43328 Tracking Number BB2 Specialty Society Recommended RVU: **27.00**

Global Period: 090 RUC Recommended RVU: **27.00**

CPT Descriptor: Esophagogastric fundoplasty partial or complete; thoracotomy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 49-year-old male who has a hostile abdomen from multiple previous abdominal surgeries has a large sliding hiatus hernia. His symptoms are severe heartburn and regurgitation. The symptoms are unresponsive to medication and the patient is referred for surgical repair.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Moderate Sedation

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

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

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

Description of Pre-Service Work: 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. Review results of preadmission labs and imaging. 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 draped. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A left thoracotomy is made and the inferior pulmonary ligament is divided to mobilize the lung and expose the mediastinum. The mediastinal pleura is incised overlying the esophagus from the aortic arch down to the diaphragm. The esophagus is mobilized circumferentially beginning immediately under the arch and extending down to the gastroesophageal junction. The hernia sac is identified and opened anterior to the esophagus. The sac is then divided circumferentially along both crural pillars. This entails dividing Belsey's artery and entering the lesser sac in the retroesophageal space. If the gastroesophageal junction cannot be easily reduced 3 cm below the hiatus a lengthening procedure is performed (reported separately). A 56 French esophageal dilator is then advanced into the esophagus by the anesthesiologist so that it can be used to appropriately "size" the crural repair and fundoplication. The posterior fundic wall

is brought posterior to the esophagus while the anterior fundus is folded over the anterior aspect of the gastroesophageal junction. The fundoplication is done by placing three sutures to fashion a circumferential wrap of the stomach around the esophagus just above the gastroesophageal junction. Each suture encompasses a generous bite of the anterior fundic wall, the esophageal musculature, and the retroesophageal posterior fundic wall. The fundoplication is then reduced below the diaphragm into the abdomen. The crural pillars are apposed with 1 to 3 sutures posterior to the esophagus to narrow th hiatus. The dilator is removed, hemostasis is obtained, and the thoracic cavity is irrigated with saline. A chest tube is placed, the lung re-expanded and the thoracotomy incision is then closed.

Description of Post-Service Work:
Hospital: Apply sterile dressings. Monitor patient during reversal of anesthesia. Avoidance of sudden straining during extubation is stressed. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia and anti-emetics. 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 ICU and discuss ongoing care with floor nurses. Order x-rays as per routine. Examine patient, including reviewing vital signs and respiratory status. 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 (eg. 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 di 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 progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Keith Naunheim, MD, FACS; Francis Nichols, MD, FACS; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS				
Specialty(s):	cardiothoracic surgery; general surgery				
CPT Code:	43328				
Sample Size:	600	**Resp N:**	47	**Response:** 7.8 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	3.00	30.00
Survey RVW:	20.00	23.30	**27.00**	31.25	42.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	90.00	120.00	**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):	**170.00**	99231x **1.00** 99232x **1.00** 99233x **2.00**
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:	43328	**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:		**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):	**170.00**	99231x **1.00** 99232x **1.00** 99233x **2.00**
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? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43282	090	30.10	**RUC Time**

CPT Descriptor Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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:** 21.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 43328**	**Key Reference CPT Code:** 43282	**Source of Time RUC Time**
Median Pre-Service Time	80.00	70.00	
Median Intra-Service Time	150.00	210.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	170.0	60.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	46.0	46.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**514.00**	**454.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.50	2.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.20
Urgency of medical decision making	2.50	2.60
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.10	3.80
Physical effort required	4.00	3.70
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.40	3.10
Outcome depends on the skill and judgment of physician	4.40	3.90
Estimated risk of malpractice suit with poor outcome	3.60	3.30

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.60	3.30
Intra-Service intensity/complexity	3.80	3.50
Post-Service intensity/complexity	3.40	3.00

Additional Rationale and Comments

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

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

The change in the work to repair an esophageal hernia over time has resulted in confusion and deficiencies in the coding structure necessitating a revision of the current CPT codes. When the original paraesophageal hernia repair codes were introduced, they were meant to report anatomic defects within the diaphragm. Dr. Allison originated these repairs and emphasized the importance of the diaphragm in the pathophysiology of hiatus hernias (Allison PR, Ann Surg 1973;178:273-6). Thus for many years (in the now distant past), paraesophageal hernias were repaired by simply reducing the hernia contents below the diaphragm and narrowing the diaphragmatic crura with suture to prevent re-herniation. These repairs were performed in an open fashion by either a transabdominal or transthoracic approach. Sometimes tacking sutures were used to fix the stomach to the abdominal wall or occasionally a gastrostomy tube was placed to fix the stomach in place so it would not re-herniate. Occasionally, strictures were dilated or concomitant ulcer disease was treated by vagotomy and pyloroplasty.

Because this was the era prior to modern anti-acid treatment with H2 histamine blockers and PPIs, esophageal strictures requiring treatment were frequent occurrences in paraesophageal hernia patients. In addition, ulcer disease of the stomach and duodenum was also common at that time because H. pylori had not yet been recognized as an etiologic agent. It was therefore frequent to find giant paraesophageal hernias associated with concomitant strictures and/or ulcer disease. For these reasons, the diaphragmatic hernia repair codes were written to include concomitant treatment for strictures (with and without dilation) and ulcer disease (with or without vagotomy and pyloroplasty). However, in 2010, these treatments (dilation, V&P) are virtually never performed concomitant with paraesophageal hernia repair, and thus the codes as written do not reflect current therapy.

Modern investigation has emphasized the importance of the lower esophageal sphincter's ability to generate pressure to prevent gastroesophageal reflux and the need to augment sphincter pressure with fundoplication, typically a 360 degree full wrap (Nissen) or a partial wrap (Belsey, Mark IV, Toupet). With this further understanding of the pathophysiology, these defects have now been reclassified as variants of hiatal hernia. The current coding schema is in direct opposition to this modern classification. The adjunctive surgical procedures of intraoperative dilatation, vagotomy, and pyloroplasty are now virtually never concomitantly performed with paraesophageal hernia repair; however, fundoplasty is almost always performed. Esophageal dilatation, if needed, is now done by gastroenterologists before any surgical procedure.

In summary, the work described by the current (to-be-deleted) codes was intended for patients with reflux/acid (chemical symptoms) or blockage (mechanical symptoms). With the advent of medical management and less invasive treatments, the patients currently undergoing surgery are symptomatic, typically with blockage. The typical patient has more advanced disease and requires more complex repair.

Recommendation – BB1 (43327) and BB2 (43328)
The Society of Thoracic Surgeons and the American College of Surgeons conducted a RUC survey and received 64 responses for BB1 and 47 responses for BB2. A consensus panel of cardiothoracic surgeons and general surgeons reviewed the survey data and agree that the median intra-operative time of 120 minutes is an accurate reflection of the time to perform BB1. This is the same intra-time from the previous survey of general surgeons and reflective of intra-time required for the abdominal approach to perform a Nissen. The panel also agrees that the thoracic approach would take longer and agree with the 150 minutes of intra-time for BB2. With respect to post-op hospital visits, the panel notes that the patients (both BB1 and BB2) would be transferred to the ICU post-operatively. Although the patient is unstable and requires ICU attention, the surgeon would not typically provide critical care for more than 30 minutes per day and so we have chosen level three post-op hospital visit(s) to account for the ICU care.

While the panel believes that the current RVWs for 43324 are relatively accurate for the abdominal Nissen, we are recommending an RVW of 18.10 for BB1 (which is less than the current value) and survey median RVW of 27.00 for BB2, the thoracic Nissen. These recommendations result in total RVUs that are less than work neutral for theses codes.

Pre-time package 4 (difficult patient/difficult) procedure is appropriate for BB1 and BB2. Additional time was added BB2 for positioning; patient is placed in lateral decubitus position with attention to padding to protect the nerves for th lengthy 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) 43324 (or 43326 if a gastroplasty was also performed)

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

Specialty thoracic surgery — How often? Sometimes

Specialty cardiac surgery — How often? Sometimes

Specialty general surgery — How often? Rarely

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

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 302
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. BB2 was previously reported with 43324 or 43326. A review of the frequency for all deleted codes and croswalking to new codes resulted in an estimate of (20% x frequency of 43324) plus (10% frequency of 43326).

Specialty cardiothoracic surgery	Frequency 287	Percentage 95.03 %
Specialty general surgery	Frequency 15	Percentage 4.96 %

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 35601 - procedure familiar to cardiothoracic surgeons with similar RVW and total time

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43332 Tracking Number BB3 Specialty Society Recommended RVU: **26.60**

Global Period: 090 RUC Recommended RVU: **26.60**

CPT Descriptor: Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74-year-old female has an intrathoracic herniation of the stomach. Her symptoms are intermittent dysphagia, prandial chest pain, and regurgitation. The symptoms are unresponsive to medication and the patient is referred for surgical repair.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Moderate Sedation

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

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

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

Description of Pre-Service Work: 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. Review results of preadmission labs and imaging. 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 draped. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A midline laparotomy is made and the left lobe of the liver is mobilized to expose the hiatus. Adhesions between the liver, stomach, and crura are meticulously taken down. The crura are identified and the hernia sac is entered to allow access to the intrathoracic stomach. The stomach is mobilized out of the sac and reduced into the abdomen and a dissection plane is established outside the hernia sac beginning at the edge of the hiatus. The hernia sac is mobilized circumferentially and reduced into the abdominal cavity. The sac is then resected off the gastroesophageal junction taking care not to harm the vagus nerve. The gastroesophageal junction is dissected circumferentially and an intrathoracic mobilization of the distal esophagus is accomplished. If the gastroesophageal junction cannot be easily

reduced 3 cm below the hiatus a lengthening procedure is performed (reported separately). If not previously divided, the short gastric vessels, gastrophrenic and gastrosplenic ligaments are taken down, creating a generous retroesophageal window. A 56 French esophageal dilator is advanced into the esophagus by the anesthesiologist so that it can be used to appropriately "size" the crural repair and fundoplication. The crural pillars are then reapposed with 3 to 5 sutures posteriorly to narrow the grossly enlarged hiatus. The posterior fundic wall is then brought through the retroesophage window so that it lies to the right of the esophagus. The complete fundoplication is constructed by bringing the anterio. fundus over the top of the gastroesophageal junction and sewing it to the posterior fundus with three sutures. Each suture encompasses a generous bite of the anterior fundic wall, the esophageal musculature, and the retroesophageal posterior fundic wall. A partial wrap would entail suturing fundic wall to each respective crus and esophagus. The dilator is removed, hemostasis is obtained, and the peritoneal cavity is irrigated with saline. The midline laparotomy incision is then closed.

Description of Post-Service Work:
Hospital: Apply sterile dressings. Monitor patient during reversal of anesthesia. Avoidance of sudden straining during extubation is stressed. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia and anti-emetics. 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 ICU and discuss ongoing care with floor nurses. Order x-rays as per routine. Examine patient, including reviewing vital signs and respiratory status. 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 (eg. 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 nutrition 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 progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010					
Presenter(s):	Keith Naunheim, MD, FACS; Francis Nichols, MD, FACS; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS					
Specialty(s):	cardiothoracic surgery; general surgery					
CPT Code:	43332					
Sample Size:	600	**Resp N:**	64	**Response:** 10.6 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	5.00	45.00
Survey RVW:	18.00	24.00	**26.60**	28.00	35.00
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	**150.00**	180.00	240.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**155.00**	99231x **1.00** 99232x **2.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
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:	43332	**Recommended Physician Work RVU: 26.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**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):	**155.00**	99231x **1.00** 99232x **2.00** 99233x **1.00**
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? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43281	090	26.60	**RUC Time**

CPT Descriptor Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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: 33 **% of respondents:** 51.5 %

TIME ESTIMATES (Median)	CPT Code: 43332	Key Reference CPT Code: 43281	Source of Time RUC Time
Median Pre-Service Time	63.00	70.00	
Median Intra-Service Time	150.00	180.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	155.0	60.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	46.0	46.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**482.00**	**424.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.18	3.09
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.61	3.50
Urgency of medical decision making	2.82	2.81
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.91	4.03
Physical effort required	3.61	3.66
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.64	3.56
Outcome depends on the skill and judgment of physician	4.06	0.13
Estimated risk of malpractice suit with poor outcome	3.27	3.25

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.45	3.44
Intra-Service intensity/complexity	3.91	3.97
Post-Service intensity/complexity	3.21	3.13

Additional Rationale and Comments

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

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

The change in the work to repair an esophageal hernia over time has resulted in confusion and deficiencies in the coding structure necessitating a revision of the current CPT codes. When the original paraesophageal hernia repair codes were introduced, they were meant to report anatomic defects within the diaphragm. Dr. Allison originated these repairs and emphasized the importance of the diaphragm in the pathophysiology of hiatus hernias (Allison PR, Ann Surg 1973;178:273-6). Thus for many years (in the now distant past), paraesophageal hernias were repaired by simply reducing the hernia contents below the diaphragm and narrowing the diaphragmatic crura with suture to prevent re-herniation. These repairs were performed in an open fashion by either a transabdominal or transthoracic approach. Sometimes tacking sutures were used to fix the stomach to the abdominal wall or occasionally a gastrostomy tube was placed to fix the stomach in place so it would not re-herniate. Occasionally, strictures were dilated or concomitant ulcer disease was treated by vagotomy and pyloroplasty.

Because this was the era prior to modern anti-acid treatment with H2 histamine blockers and PPIs, esophageal strictures requiring treatment were frequent occurrences in paraesophageal hernia patients. In addition, ulcer disease of the stomach and duodenum was also common at that time because H. pylori had not yet been recognized as an etiologic agent. It was therefore frequent to find giant paraesophageal hernias associated with concomitant strictures and/or ulcer disease. For these reasons, the diaphragmatic hernia repair codes were written to include concomitant treatment for strictures (with and without dilation) and ulcer disease (with or without vagotomy and pyloroplasty). However, in 2010, these treatments (dilation, V&P) are virtually never performed concomitant with paraesophageal hernia repair, and thus the codes as written do not reflect current therapy.

Modern investigation has emphasized the importance of the lower esophageal sphincter's ability to generate pressure to prevent gastroesophageal reflux and the need to augment sphincter pressure with fundoplication, typically a 360 degree full wrap (Nissen) or a partial wrap (Belsey, Mark IV, Toupet). With this further understanding of the pathophysiology, these defects have now been reclassified as variants of hiatal hernia. The current coding schema is in direct opposition to this modern classification. The adjunctive surgical procedures of intraoperative dilatation, vagotomy, and pyloroplasty are now virtually never concomitantly performed with paraesophageal hernia repair; however, fundoplasty is almost always performed. Esophageal dilatation, if needed, is now done by gastroenterologists before any surgical procedure.

In summary, the work described by the current (to-be-deleted) codes was intended for patients with reflux/acid (chemical symptoms) or blockage (mechanical symptoms). With the advent of medical management and less invasive treatments, the patients currently undergoing surgery are symptomatic, typically with blockage. The typical patient has more advanced disease and requires more complex repair.

Recommendation – BB3 (43328) and BB4 (43333)
The Society of Thoracic Surgeons and the American College of Surgeons conducted a RUC survey and received 64 responses for BB3 and 63 responses for BB4. A consensus panel of cardiothoracic surgeons and general surgeons reviewed the survey data and agree that the median intra-operative time of 150 minutes is an accurate reflection of the time to perform BB3. The panel also agrees that the BB4 (with mesh) would reasonably incur an additional 30 minutes of time. With respect to post-op hospital visits, the panel notes that the patients (both BB3 and BB4) would be transferred to the ICU post-operatively. Although the patient is unstable and requires ICU attention, the surgeon would not typically provide critical care for more than 30 minutes per day and so we have chosen level three post-op hospital visit(s) to account for the ICU care.

As discussed above in the compelling evidence section, the work and the severity of illness of the patient treated with new codes BB3 and BB4 is greater than the work originally described by 39502. New codes BB3 and BB4 will always include fundoplasty in current practice and patients that have typically failed medical management and/or less invasive treatments. Additionally, new code BB4 will add the new work of mesh implantation.

We are recommending the survey median RVW of 26.60 for BB3 and the survey median RVW of 30.00 for BB4. The recommendations are supported by the key reference codes 43281 and 43282 (reviewed by the RUC in 2009), which are the laparoscopic versions of BB3 and BB4. Although the intra-time for the laparoscopic codes is greater than BB3 and BB4, the post-operative work is less. The consensus panel believes that total work for current practice is approximately the same. The difference in work for the implantation of mesh at 3.40 RVWs is consistent with the difference in the

laparoscopic codes. This differential RVW compares well with ZZZ add-on 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* which has a greater intra-time. (RVW 4.58, intra-time 52 min).

Pre-time package 4 (difficult patient/difficult procedure) is appropriate for both BB3 and BB4.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 39502 or 43326

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

Specialty thoracic surgery	How often?
Specialty cardiac surgery	How often?
Specialty general surgery	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. Not able to estimate national frequency

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,169
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. BB3 was previously reported with 39502 or 43326. A review of the frequency for

all deleted codes and croswalking to new codes resulted in an estimate of (100% x frequency of 39502) plus (25% frequency of 43326) multiplied by 80%. The other 20% would be reported as BB4 - with mesh.

Specialty general surgery Frequency 2060 Percentage 94.97 %

Specialty cardiothoracic surgery Frequency 108 Percentage 4.97 %

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? (ie. similar work RVU, and specialty) 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

	SURVEY CODES		APPROACH	Est freq						
BB1	**4332X**	Nissen	abdominal	**1,206**	**43324**	1,121	80% gs	**43326**	85	40% gs
BB2	**4332X1**	Nissen	thoracic	**302**	**43324**	280	20% cts	**43326**	21	10% cts
BB3	**4332X2**	PEH	abdominal	**2,169**	**43326**	53	25% gs	**39502**	2,658	all
BB4	**4332X21**	PEH w/mesh	abdominal	**542**	X	434	20% of w/o mesh			
BB5	**4332X3**	PEH	thoracic	**326**	**43326**	21	10% cts	**39520**	387	all
BB6	**4332X31**	PEH w/mesh	thoracic	**82**	X	65	20% of w/o mesh			
BB7	**4332X4**	PEH	thoro-abdom	**101**	**43326**	11	5% any	**39530** **39531**	115	all
BB8	**4332X41**	PEH w/mesh	thoro-abdom	**25**	X	20	20% of w/o mesh			
BB9	**4332X5**	open Collis	open	**64**	**43326**	64	30% total			
BB10	**4328X**	Lap Collis	laparoscopic	**80**	**NEW**	80	25% more than open			

X=39599 or 43499 (NEW - with mesh)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43333 Tracking Number BB4 Specialty Society Recommended RVU: **30.00**

Global Period: 090 RUC Recommended RVU: **30.00**

CPT Descriptor: Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74-year-old female has an intrathoracic herniation of the stomach. Her symptoms are intermittent dysphagia, prandial chest pain, and regurgitation. The symptoms are unresponsive to medication and the patient is referred for surgical repair.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an &M service later on the same day 100%

Moderate Sedation

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

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

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

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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. Review results of preadmission labs and imaging. 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 draped. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A midline laparotomy is made and the left lobe of the liver is mobilized to expose the hiatus. Adhesions between the liver, stomach, and crura are meticulously taken down. The crura are identified and the ernia sac is entered to allow access to the intrathoracic stomach. The stomach is mobilized out of the sac and reduced into the abdomen and a dissection plane is established outside the hernia sac beginning at the edge of the hiatus. The hernia sac is mobilized circumferentially and reduced into the abdominal cavity. The sac is then resected off the gastroesophageal junction taking care not to harm the vagus nerve. The gastroesophageal junction is dissected circumferentially and an intrathoracic mobilization of the distal esophagus is accomplished. If the gastroesophageal junction cannot be easily

reduced 3 cm below the hiatus a lengthening procedure is performed (reported separately). If not previously divided, the short gastric vessels, gastrophrenic and gastrosplenic ligaments are taken down, creating a generous retroesophageal window. A 56 French esophageal dilator is advanced into the esophagus by the anesthesiologist so that it can be used to appropriately "size" the crural repair and fundoplication. The crural pillars are then reapproximated in a trial fashion but the hiatus is too large and flimsy to allow closure without significant tension without mesh. Accordingly mesh is broug' onto the field and sized to the approximate size of the crura. The mesh is then sewed onto the margins of the crura allowin the appropriate opening for the esophagus or as a buttress to strengthen repair and serve as a fascial support function. The posterior fundic wall is then brought through the retroesophageal window so that it lies to the right of the esophagus. A complete fundoplication is constructed by bringing the anterior fundus over the top of the gastroesophageal junction and sewing it to the posterior fundus with three sutures. Each suture encompasses a generous bite of the anterior fundic wall, the esophageal musculature, and the retroesophageal posterior fundic wall. A partial wrap would suture fundus to each respective crus and esophagus. The dilator is removed, hemostasis is obtained, and the peritoneal cavity is irrigated with saline. The midline laparotomy incision is then closed.

Description of Post-Service Work:
Hospital: Apply sterile dressings. Monitor patient during reversal of anesthesia. Avoidance of sudden straining during extubation is stressed. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia and anti-emetics. 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 ICU and discuss ongoing care with floor nurses. Order x-rays as per routine. Examine patient, including reviewing vital signs and respiratory status. 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 (eg. 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 medicatio 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 progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010					
Presenter(s):	Keith Naunheim, MD, FACS; Francis Nichols, MD, FACS; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS					
Specialty(s):	cardiothoracic surgery; general surgery					
CPT Code:	43333					
Sample Size:	600	**Resp N:**	63	**Response:** 10.5 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	2.00	10.00
Survey RVW:	18.50	28.00	**30.00**	32.00	40.00
Pre-Service Evaluation Time:			**55.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	100.00	150.00	**180.00**	230.00	270.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**155.00**	99231x **1.00** 99232x **2.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
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:	43333	**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:		**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):	**155.00**	99231x **1.00** 99232x **2.00** 99233x **1.00**
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? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43282	090	30.10	**RUC Time**

CPT Descriptor Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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: 32 **% of respondents:** 50.7 %

TIME ESTIMATES (Median)	**CPT Code: 43333**	**Key Reference CPT Code: 43282**	**Source of Time RUC Time**
Median Pre-Service Time	63.00	70.00	
Median Intra-Service Time	180.00	210.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	155.0	60.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	46.0	46.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**512.00**	**454.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.29	3.21
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.52	3.41
Urgency of medical decision making	2.87	2.83
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.19	4.34
Physical effort required	3.87	3.93
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.84	3.79
Outcome depends on the skill and judgment of physician	4.16	4.24
`stimated risk of malpractice suit with poor outcome	3.29	3.24

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.50	3.47
Intra-Service intensity/complexity	4.19	4.27
Post-Service intensity/complexity	3.31	3.20

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 `ecommendations for the appropriate formula and format.*

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

The change in the work to repair an esophageal hernia over time has resulted in confusion and deficiencies in the coding structure necessitating a revision of the current CPT codes. When the original paraesophageal hernia repair codes were introduced, they were meant to report anatomic defects within the diaphragm. Dr. Allison originated these repairs and emphasized the importance of the diaphragm in the pathophysiology of hiatus hernias (Allison PR, Ann Surg 1973;178:273-6). Thus for many years (in the now distant past), paraesophageal hernias were repaired by simply reducing the hernia contents below the diaphragm and narrowing the diaphragmatic crura with suture to prevent re-herniation. These repairs were performed in an open fashion by either a transabdominal or transthoracic approach. Sometimes tacking sutures were used to fix the stomach to the abdominal wall or occasionally a gastrostomy tube was placed to fix the stomach in place so it would not re-herniate. Occasionally, strictures were dilated or concomitant ulcer disease was treated by vagotomy and pyloroplasty.

Because this was the era prior to modern anti-acid treatment with H2 histamine blockers and PPIs, esophageal strictures requiring treatment were frequent occurrences in paraesophageal hernia patients. In addition, ulcer disease of the stomach and duodenum was also common at that time because H. pylori had not yet been recognized as an etiologic agent. It was therefore frequent to find giant paraesophageal hernias associated with concomitant strictures and/or ulcer disease. For these reasons, the diaphragmatic hernia repair codes were written to include concomitant treatment for strictures (with and without dilation) and ulcer disease (with or without vagotomy and pyloroplasty). However, in 2010, these treatments (dilation, V&P) are virtually never performed concomitant with paraesophageal hernia repair, and thus the codes as written do not reflect current therapy.

Modern investigation has emphasized the importance of the lower esophageal sphincter's ability to generate pressure to prevent gastroesophageal reflux and the need to augment sphincter pressure with fundoplication, typically a 360 degree full wrap (Nissen) or a partial wrap (Belsey, Mark IV, Toupet). With this further understanding of the pathophysiology, these defects have now been reclassified as variants of hiatal hernia. The current coding schema is in direct opposition to this modern classification. The adjunctive surgical procedures of intraoperative dilatation, vagotomy, and pyloroplasty are now virtually never concomitantly performed with paraesophageal hernia repair; however, fundoplasty is almost always performed. Esophageal dilatation, if needed, is now done by gastroenterologists before any surgical procedure.

In summary, the work described by the current (to-be-deleted) codes was intended for patients with reflux/acid (chemical symptoms) or blockage (mechanical symptoms). With the advent of medical management and less invasive treatments, the patients currently undergoing surgery are symptomatic, typically with blockage. The typical patient has more advanced disease and requires more complex repair.

Recommendation – BB3 (43332) and BB4 (43333)
The Society of Thoracic Surgeons and the American College of Surgeons conducted a RUC survey and received 64 responses for BB3 and 63 responses for BB4. A consensus panel of cardiothoracic surgeons and general surgeons reviewed the survey data and agree that the median intra-operative time of 150 minutes is an accurate reflection of the time to perform BB3. The panel also agrees that the BB4 (with mesh) would reasonably incur an additional 30 minutes of time. With respect to post-op hospital visits, the panel notes that the patients (both BB3 and BB4) would be transferred to the ICU post-operatively. Although the patient is unstable and requires ICU attention, the surgeon would not typically provide critical care for more than 30 minutes per day and so we have chosen level three post-op hospital visit(s) to account for the ICU care.

As discussed above in the compelling evidence section, the work and the severity of illness of the patient treated with new codes BB3 and BB4 is greater than the work originally described by 39502. New codes BB3 and BB4 will always include fundoplasty in current practice and patients that have typically failed medical management and/or less invasive treatments. Additionally, new code BB4 will add the new work of mesh implantation.

We are recommending the survey median RVW of 26.60 for BB3 and the survey median RVW of 30.00 for BB4. The recommendations are supported by the key reference codes 43281 and 43282 (reviewed by the RUC in 2009), which are the laparoscopic versions of BB3 and BB4. Although the intra-time for the laparoscopic codes is greater than BB3 and BB4, the post-operative work is less. The consensus panel believes that total work for current practice is approximately the same. The difference in work for the implantation of mesh at 3.40 RVWs is consistent with the difference in the

laparoscopic codes. This differential RVW compares well with ZZZ add-on 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* which has a greater intra-time. (RVW 4.58, intra-time 52 min).

re-time package 4 (difficult patient/difficult procedure) is appropriate for both BB3 and BB4.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 39599 or 43499

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

Specialty thoracic surgery	How often? Rarely
Specialty cardiac surgery	How often? Rarely
Specialty general surgery	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. Not able to estimate national frequency

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? 813
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please

explain the rationale for this estimate. BB4 was previously reported with unlisted codes. This estimate is based on consideration of the frequency for BB3.

Specialty general surgery Frequency 772 Percentage 94.95 %

Specialty cardiothoracic surgery Frequency 41 Percentage 5.04 %

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? (ie. similar work RVU, and specialty) 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

	SURVEY CODES		APPROACH	Est freq						
BB1	**4332X**	Nissen	abdominal	**1,206**	**43324**	1,121	80% gs	**43326**	85	40% gs
BB2	**4332X1**	Nissen	thoracic	**302**	**43324**	280	20% cts	**43326**	21	10% cts
BB3	**4332X2**	PEH	abdominal	**2,169**	**43326**	53	25% gs	**39502**	2,658	all
BB4	**4332X21**	PEH w/mesh	abdominal	**542**	**X**	434	20% of w/o mesh			
BB5	**4332X3**	PEH	thoracic	**326**	**43326**	21	10% cts	**39520**	387	all
BB6	**4332X31**	PEH w/mesh	thoracic	**82**	X	65	20% of w/o mesh			
BB7	**4332X4**	PEH	thoro-abdom	**101**	**43326**	11	5% any	**39530** **39531**	115	all
BB8	**4332X41**	PEH w/mesh	thoro-abdom	**25**	X	20	20% of w/o mesh			
BB9	**4332X5**	open Collis	open	**64**	**43326**	64	30% total			
BB10	**4328X**	Lap Collis	laparoscopic	**80**	**NEW**	80	25% more than open			

X=39599 or 43499 (NEW - with mesh)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43334 Tracking Number BB5 Specialty Society Recommended RVU: **30.00**

Global Period: 090 RUC Recommended RVU: **30.00**

CPT Descriptor: Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old male presents with a paraesophageal hiatal hernia causing postprandial chest pain, regurgitation, and dyspnea. He has undergone multiple previous upper abdominal procedures including incisional hernia repair with mesh. He is referred for surgical repair.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 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 &M service later on the same day 100%

Moderate Sedation

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

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

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

Description of Pre-Service Work: 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. Review results of preadmission labs and imaging. 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 draped. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A left thoracotomy is made and the inferior pulmonary ligament is divided to mobilize the lung and expose the mediastinum. The mediastinal pleura is incised overlying the esophagus from the aortic arch, over e hernia sac and down to the diaphragm. The esophagus is mobilized circumferentially beginning immediately under the arch and extending down to the gastroesophageal junction. The hernia sac is identified and opened anterior to the esophagus. The sac is then divided circumferentially along both crural pillars. This entails dividing Belsey's artery and entering the lesser sac in the retroesophageal space. The hernia sac and gastroesophageal fat pad are then excised taking great care not to harm either vagus nerve during dissection. The short gastric vessels are exposed in the chest by gentle

traction on the greater curve of the stomach. These vessels are ligated and divided as are the gastrophrenic and gastrosplenic ligaments. If the gastroesophageal junction cannot be easily reduced 3 cm below the hiatus a lengthening procedure is performed (reported separately). A 56 French esophageal dilator is advanced into the esophagus by the anesthesiologist so that it can be used to appropriately "size" the crural repair and fundoplication. The posterior fundic wall is brought posterior to the esophagus while the anterior fundus is folded over the anterior aspect of th gastroesophageal junction. The fundoplication is completed by placing three sutures to fashion a circumferential wrap c the stomach around the esophagus just above the gastroesophageal junction. Each suture encompasses a generous bite of the anterior fundic wall, the esophageal musculature, and the retroesophageal posterior fundic wall. The fundoplication is then reduced below the diaphragm into the abdomen. The crural pillars are apposed with 3 to 5 sutures posterior to the esophagus to narrow the hiatus. The surgeon decides whether or not crural reinforcement is indicated and proceeds accordingly with mesh reinforcement if indicated. The dilator is removed, hemostasis is obtained, and the thoracic cavity is irrigated with saline. A chest tube is placed, the lung re-expanded and the thoracotomy incision is then closed.

Description of Post-Service Work:
Hospital: Apply sterile dressings. Monitor patient during reversal of anesthesia. Avoidance of sudden straining during extubation is stressed. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia and anti-emetics. 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 ICU and discuss ongoing ongoing care with floor nurses. Order x-rays as per routine. Examine patient, including reviewing vital signs and respiratory status. 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 (eg. 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 discusse 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 progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010					
Presenter(s):	Keith Naunheim, MD, FACS; Francis Nichols, MD, FACS; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS					
Specialty(s):	cardiothoracic surgery; general surgery					
CPT Code:	43334					
Sample Size:	600	**Resp N:**	46	**Response:** 7.6 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	5.00	50.00
Survey RVW:	20.00	27.60	**30.00**	36.00	45.00
Pre-Service Evaluation Time:			**58.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**18.00**		
Intra-Service Time:	120.00	150.00	**180.00**	210.00	320.00

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):	**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:	43334	**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:		**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):	**175.00**	99231x **2.00** 99232x **2.00** 99233x **1.00**
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? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43281	090	26.60	**RUC Time**

CPT Descriptor Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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:** 17.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 43334**	**Key Reference CPT Code: 43281**	**Source of Time RUC Time**
Median Pre-Service Time	80.00	70.00	
Median Intra-Service Time	180.00	180.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	175.0	60.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	46.0	46.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**549.00**	**424.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.25	2.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.13
Urgency of medical decision making	3.13	3.13
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.13	3.88
Physical effort required	3.75	3.38
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.63	3.50
Outcome depends on the skill and judgment of physician	4.00	4.00
Estimated risk of malpractice suit with poor outcome	3.13	3.13

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.50	3.38
Intra-Service intensity/complexity	4.13	3.88
Post-Service intensity/complexity	3.38	3.25

Additional Rationale and Comments

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

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

The change in the work to repair an esophageal hernia over time has resulted in confusion and deficiencies in the coding structure necessitating a revision of the current CPT codes. When the original paraesophageal hernia repair codes were introduced, they were meant to report anatomic defects within the diaphragm. Dr. Allison originated these repairs and emphasized the importance of the diaphragm in the pathophysiology of hiatus hernias (Allison PR, Ann Surg 1973;178:273-6). Thus for many years (in the now distant past), paraesophageal hernias were repaired by simply reducing the hernia contents below the diaphragm and narrowing the diaphragmatic crura with suture to prevent re-herniation. These repairs were performed in an open fashion by either a transabdominal or transthoracic approach. Sometimes tacking sutures were used to fix the stomach to the abdominal wall or occasionally a gastrostomy tube was placed to fix the stomach in place so it would not re-herniate. Occasionally, strictures were dilated or concomitant ulcer disease was treated by vagotomy and pyloroplasty.

Because this was the era prior to modern anti-acid treatment with H2 histamine blockers and PPIs, esophageal strictures requiring treatment were frequent occurrences in paraesophageal hernia patients. In addition, ulcer disease of the stomach and duodenum was also common at that time because H. pylori had not yet been recognized as an etiologic agent. It was therefore frequent to find giant paraesophageal hernias associated with concomitant strictures and/or ulcer disease. For these reasons, the diaphragmatic hernia repair codes were written to include concomitant treatment for strictures (with and without dilation) and ulcer disease (with or without vagotomy and pyloroplasty). However, in 2010, these treatments (dilation, V&P) are virtually never performed concomitant with paraesophageal hernia repair, and thus the codes as written do not reflect current therapy.

Modern investigation has emphasized the importance of the lower esophageal sphincter's ability to generate pressure to prevent gastroesophageal reflux and the need to augment sphincter pressure with fundoplication, typically a 360 degree full wrap (Nissen) or a partial wrap (Belsey, Mark IV, Toupet). With this further understanding of the pathophysiology, these defects have now been reclassified as variants of hiatal hernia. The current coding schema is in direct opposition to this modern classification. The adjunctive surgical procedures of intraoperative dilatation, vagotomy, and pyloroplasty are now virtually never concomitantly performed with paraesophageal hernia repair; however, fundoplasty is almost always performed. Esophageal dilatation, if needed, is now done by gastroenterologists before any surgical procedure.

In summary, the work described by the current (to-be-deleted) codes was intended for patients with reflux/acid (chemical symptoms) or blockage (mechanical symptoms). With the advent of medical management and less invasive treatments, the patients currently undergoing surgery are symptomatic, typically with blockage. The typical patient has more advanced disease and requires more complex repair.

Recommendation – BB5 (43334) and BB6 (43335)
The Society of Thoracic Surgeons and the American College of Surgeons conducted a RUC survey and received 46 responses for BB5 and 47 responses for BB6. A consensus panel of cardiothoracic surgeons and general surgeons reviewed the survey data and agree that the median intra-operative time of 180 minutes is an accurate reflection of the time to perform BB5. The panel also agrees that the BB6 (with mesh) would reasonably incur an additional 20-30 minutes of time, and accepts the median time of 210. With respect to post-op hospital visits, the panel notes that the patients (both BB5 and BB6) would be transferred to the ICU post-operatively. Although the patient is unstable and requires ICU attention, the surgeon would not typically provide critical care for more than 30 minutes per day and so we have chosen level three post-op hospital visit(s) to account for the ICU care.

As discussed above in the compelling evidence section, the work and the severity of illness of the patient treated with new codes BB5 and BB6 is greater than the work originally described by 39520. New codes BB5 and BB6 will always include fundoplasty in current practice and patients that have typically failed medical management and/or less invasive treatments. Additionally, new code BB6 will add the new work of mesh implantation.

We are recommending the survey median RVW of 30.00 for BB5 and the survey median RVW of 33.00 for BB6. These recommendations are supported by the key reference codes 43281 and 43282 (reviewed by the RUC in 2009), which are the laparoscopic versions of BB5 and BB6. The intra-time for the laparoscopic codes is the same or similar to BB5 and BB6. However, the post-operative work for the new code is considerably greater. The difference in work for the implantation of mesh at 3.00 RVWs is consistent with the difference in the laparoscopic codes. This differential RVW

compares well with ZZZ add-on 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* which has a greater intra-time. (RVW 4.58, intra-time 52 min). The frequency for BB5 and BB6 will be low as these procedures will be reserved for patients who have undergone multiple abdominal surgeries and cannot be approach through the abdomen for repair.

Pre-time package 4 difficult patient/difficult procedure is appropriate for BB5 and BB6, with additional time for positioning; patient is placed in lateral decubitus position with attention to padding to protect the nerves for the lengthy 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) 39520 or 43326

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

Specialty thoracic surgery	How often? Sometimes
Specialty cardiac 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?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Not able to estimate national frequency

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 326
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. BB5 was previously reported with 39520 or 43326. A review of the frequency for all deleted codes and croswalking to new codes resulted in an estimate of (100% x frequency of 39520) plus (10% frequency of 43326) multiplied by 80%. The other 20% would be reported as BB6 - with mesh.

Specialty cardiothoracic surgery Frequency 310 Percentage 95.09 %

Specialty general surgery Frequency 16 Percentage 4.90 %

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? (ie. similar work RVU, and specialty) 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

	SURVEY CODES		APPROACH	Est freq						
BB1	**4332X**	Nissen	abdominal	**1,206**	**43324**	1,121	80% gs	**43326**	85	40% gs
BB2	**4332X1**	Nissen	thoracic	**302**	**43324**	280	20% cts	**43326**	21	10% cts
BB3	**4332X2**	PEH	abdominal	**2,169**	**43326**	53	25% gs	**39502**	2,658	all
BB4	**4332X21**	PEH w/mesh	abdominal	**542**	**X**	434	20% of w/o mesh			
BB5	**4332X3**	PEH	thoracic	**326**	**43326**	21	10% cts	**39520**	387	all
BB6	**4332X31**	PEH w/mesh	thoracic	**82**	**X**	65	20% of w/o mesh			
BB7	**4332X4**	PEH	thoro-abdom	**101**	**43326**	11	5% any	**39530** **39531**	115	all
BB8	**4332X41**	PEH w/mesh	thoro-abdom	**25**	**X**	20	20% of w/o mesh			
BB9	**4332X5**	open Collis	open	**64**	**43326**	64	30% total			
BB10	**4328X**	Lap Collis	laparoscopic	**80**	**NEW**	80	25% more than open			

X=39599 or 43499 (NEW - with mesh)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43335 Tracking Number BB6 Specialty Society Recommended RVU: **33.00**

Global Period: 090 RUC Recommended RVU: **33.00**

CPT Descriptor: Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old male presents with a paraesophageal hiatal hernia causing postprandial chest pain, regurgitation, and dyspnea. He has undergone multiple previous upper abdominal procedures including incisional hernia repair with mesh. He is referred for surgical repair.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an &M service later on the same day 100%

Moderate Sedation

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

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

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

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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. Review results of preadmission labs and imaging. 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 draped. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A left thoracotomy is made and the inferior pulmonary ligament is divided to mobilize the lung and expose the mediastinum. The mediastinal pleura is incised overlying the esophagus from the aortic arch, over e hernia sac and down to the diaphragm. The esophagus is mobilized circumferentially beginning immediately under the arch and extending down to the gastroesophageal junction. The hernia sac is identified and opened anterior to the esophagus. The sac is then divided circumferentially along both crural pillars. This entails dividing Belsey's artery and entering the lesser sac in the retroesophageal space. The hernia sac and gastroesophageal fat pad are then excised taking great care not to harm either vagus nerve during dissection. The short gastric vessels are exposed in the chest by gentle

traction on the greater curve of the stomach. These vessels are ligated and divided as are the gastrophrenic and gastrosplenic ligaments. If the gastroesophageal junction cannot be easily reduced 3 cm below the hiatus a lengthening procedure is performed (reported separately). A 56 French esophageal dilator is advanced into the esophagus by the anesthesiologist so that it can be used to appropriately "size" the crural repair and fundoplication. The posterior fundic wall is brought posterior to the esophagus while the anterior fundus is folded over the anterior aspect of the gastroesophage junction. The fundoplication is completed by placing three sutures to fashion a circumferential wrap of the stomach aroun the esophagus just above the gastroesophageal junction. Each suture encompasses a generous bite of the anterior fundic wall, the esophageal musculature, and the retroesophageal posterior fundic wall. The fundoplication is then reduced below the diaphragm into the abdomen. The crural pillars are apposed in a preliminary fashion which reveals undue tension on the crura which are very thin. Accordingly mesh is brought onto the field and sized appropriately for the widened crural defect. The mesh is then sewn along the rim of the crura leaving the appropriate amount of opening around the esophagus. The dilator is removed, hemostasis is obtained, and the thoracic cavity is irrigated with saline. A chest tube is placed, the lung re-expanded and the thoracotomy incision is then closed.

Description of Post-Service Work:
Hospital: Apply sterile dressings. Monitor patient during reversal of anesthesia. Avoidance of sudden straining during extubation is stressed. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia and anti-emetics. 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 ICU and discuss ongoing care with floor nurses. Order x-rays as per routine. Examine patient, including reviewing vital signs and respiratory status. 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 (eg. 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 medicatio 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 progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010					
Presenter(s):	Keith Naunheim, MD, FACS; Francis Nichols, MD, FACS; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS					
Specialty(s):	cardiothoracic surgery; general surgery					
CPT Code:	43335					
Sample Size:	600	**Resp N:**	47	**Response:** 7.8 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	2.00	6.00
Survey RVW:	20.00	30.00	**33.00**	37.00	46.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	120.00	180.00	**200.00**	240.00	360.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**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):	**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:	43335	**Recommended Physician Work RVU: 33.00**		
		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:		**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):	**175.00**	99231x **2.00** 99232x **2.00** 99233x **1.00**
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? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43282	090	30.10	**RUC Time**

CPT Descriptor Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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:** 34.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 43335**	**Key Reference CPT Code:** 43282	**Source of Time** RUC Time
Median Pre-Service Time	80.00	70.00	
Median Intra-Service Time	200.00	210.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	175.0	60.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	46.0	46.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**569.00**	**454.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.63	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.81	3.44
Urgency of medical decision making	3.06	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.38	4.13
Physical effort required	4.06	3.69
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	3.75
Outcome depends on the skill and judgment of physician	4.31	4.31
Estimated risk of malpractice suit with poor outcome	3.50	3.31

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.69	3.56
Intra-Service intensity/complexity	4.19	4.00
Post-Service intensity/complexity	3.44	3.19

Additional Rationale and Comments

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

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

The change in the work to repair an esophageal hernia over time has resulted in confusion and deficiencies in the coding structure necessitating a revision of the current CPT codes. When the original paraesophageal hernia repair codes were introduced, they were meant to report anatomic defects within the diaphragm. Dr. Allison originated these repairs and emphasized the importance of the diaphragm in the pathophysiology of hiatus hernias (Allison PR, Ann Surg 1973;178:273-6). Thus for many years (in the now distant past), paraesophageal hernias were repaired by simply reducing the hernia contents below the diaphragm and narrowing the diaphragmatic crura with suture to prevent re-herniation. These repairs were performed in an open fashion by either a transabdominal or transthoracic approach. Sometimes tacking sutures were used to fix the stomach to the abdominal wall or occasionally a gastrostomy tube was placed to fix the stomach in place so it would not re-herniate. Occasionally, strictures were dilated or concomitant ulcer disease was treated by vagotomy and pyloroplasty.

Because this was the era prior to modern anti-acid treatment with H2 histamine blockers and PPIs, esophageal strictures requiring treatment were frequent occurrences in paraesophageal hernia patients. In addition, ulcer disease of the stomach and duodenum was also common at that time because H. pylori had not yet been recognized as an etiologic agent. It was therefore frequent to find giant paraesophageal hernias associated with concomitant strictures and/or ulcer disease. For these reasons, the diaphragmatic hernia repair codes were written to include concomitant treatment for strictures (with and without dilation) and ulcer disease (with or without vagotomy and pyloroplasty). However, in 2010, these treatments (dilation, V&P) are virtually never performed concomitant with paraesophageal hernia repair, and thus the codes as written do not reflect current therapy.

Modern investigation has emphasized the importance of the lower esophageal sphincter's ability to generate pressure to prevent gastroesophageal reflux and the need to augment sphincter pressure with fundoplication, typically a 360 degree full wrap (Nissen) or a partial wrap (Belsey, Mark IV, Toupet). With this further understanding of the pathophysiology, these defects have now been reclassified as variants of hiatal hernia. The current coding schema is in direct opposition to this modern classification. The adjunctive surgical procedures of intraoperative dilatation, vagotomy, and pyloroplasty are now virtually never concomitantly performed with paraesophageal hernia repair; however, fundoplasty is almost always performed. Esophageal dilatation, if needed, is now done by gastroenterologists before any surgical procedure.

In summary, the work described by the current (to-be-deleted) codes was intended for patients with reflux/acid (chemical symptoms) or blockage (mechanical symptoms). With the advent of medical management and less invasive treatments, the patients currently undergoing surgery are symptomatic, typically with blockage. The typical patient has more advanced disease and requires more complex repair.

Recommendation – BB5 (43334) and BB6 (43335)
The Society of Thoracic Surgeons and the American College of Surgeons conducted a RUC survey and received 46 responses for BB5 and 47 responses for BB6. A consensus panel of cardiothoracic surgeons and general surgeons reviewed the survey data and agree that the median intra-operative time of 180 minutes is an accurate reflection of the time to perform BB5. The panel also agrees that the BB6 (with mesh) would reasonably incur an additional 20-30 minutes of time, and accepts the median time of 210. With respect to post-op hospital visits, the panel notes that the patients (both BB5 and BB6) would be transferred to the ICU post-operatively. Although the patient is unstable and requires ICU attention, the surgeon would not typically provide critical care for more than 30 minutes per day and so we have chosen level three post-op hospital visit(s) to account for the ICU care.

As discussed above in the compelling evidence section, the work and the severity of illness of the patient treated with new codes BB5 and BB6 is greater than the work originally described by 39520. New codes BB5 and BB6 will always include fundoplasty in current practice and patients that have typically failed medical management and/or less invasive treatments. Additionally, new code BB6 will add the new work of mesh implantation.

We are recommending the survey median RVW of 30.00 for BB5 and the survey median RVW of 33.00 for BB6. The recommendations are supported by the key reference codes 43281 and 43282 (reviewed by the RUC in 2009), which are the laparoscopic versions of BB5 and BB6. The intra-time for the laparoscopic codes is the same or similar to BB5 and BB6. However, the post-operative work for the new code is considerably greater. The difference in work for the implantation of mesh at 3.00 RVWs is consistent with the difference in the laparoscopic codes. This differential RVW

compares well with ZZZ add-on 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* which has a greater intra-time. (RVW 4.58, intra-time 52 min). The frequency for BB5 and BB6 will be low as these procedures will be reserved for patients who have undergone multiple abdominal surgeries and cannot be approach through the abdomen for repair.

Pre-time package 4 difficult patient/difficult procedure is appropriate for BB5 and BB6, with additional time for positioning; patient is placed in lateral decubitus position with attention to padding to protect the nerves for the lengthy 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) 39599 or 43499

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

Specialty thoracic surgery	How often? Sometimes
Specialty cardiac 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?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Not able to estimate national frequency

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 82 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. BB6 was previously reported with unlisted codes. This estimate is based on consideration of the frequency for BB5.

Specialty cardiothoracic surgery Frequency 78 Percentage 95.12 %

Specialty general surgery Frequency 4 Percentage 4.87 %

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? (ie. similar work RVU, and specialty) 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

	SURVEY CODES		APPROACH	Est freq						
BB1	**4332X**	Nissen	abdominal	**1,206**	**43324**	1,121	80% gs	**43326**	85	40% gs
BB2	**4332X1**	Nissen	thoracic	**302**	**43324**	280	20% cts	**43326**	21	10% cts
BB3	**4332X2**	PEH	abdominal	**2,169**	**43326**	53	25% gs	**39502**	2,658	all
BB4	**4332X21**	PEH w/mesh	abdominal	**542**	**X**	434	20% of w/o mesh			
BB5	**4332X3**	PEH	thoracic	**326**	**43326**	21	10% cts	**39520**	387	all
BB6	**4332X31**	PEH w/mesh	thoracic	**82**	**X**	65	20% of w/o mesh			
BB7	**4332X4**	PEH	thoro-abdom	**101**	**43326**	11	5% any	**39530** **39531**	115	all
BB8	**4332X41**	PEH w/mesh	thoro-abdom	**25**	**X**	20	20% of w/o mesh			
BB9	**4332X5**	open Collis	open	**64**	**43326**	64	30% total			
BB10	**4328X**	Lap Collis	laparoscopic	**80**	**NEW**	80	25% more than open			

X=39599 or 43499 (NEW - with mesh)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43336 Tracking Number BB7 Specialty Society Recommended RVU: **35.00**

Global Period: 090 RUC Recommended RVU: **35.00**

CPT Descriptor: Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old female has undergone two previous antireflux procedures and now presents with recurrent severe substernal burning, nocturnal waterbrash, and dysphagia secondary to a recurrent paraesophageal hernia. Imaging confirms the wrap has broken down and the hernia has recurred. The patient is referred for repeat antireflux surgery.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

ercent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Moderate Sedation

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

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

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

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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. Review results of preadmission labs and imaging. 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 draped. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: A left thoracotomy is made in the 7th interspace and extended across the costal cartilage into the abdominal musculature. The abdomen and chest are entered the inferior pulmonary ligament is divided to mobilize the lung and expose the mediastinum. The mediastinal pleura is incised overlying the esophagus from the aortic arch down to the diaphragm. Adhesions surrounding the previously dissected esophagus are carefully taken down and the esophagus is mobilized circumferentially beginning immediately under the arch and extending down to the gastroesophageal junction. The diaphragm is incised and taken down off the chest wall circumferentially. The

subdiaphragmatic adhesions which fix the gastric body to the liver and crura and prevent reduction of the stomach into the abdomen are than carefully dissected. A 56 French esophageal dilator is advanced into the esophagus by the anesthesiologist so that it can be used to appropriately "size" the crural repair and fundoplication. The gastroesophageal junction is reduced 3 cms into the abdomen. If this cannot be accomplished a lengthening procedure is performed (reported separately). The posterior fundic wall is then brought posterior to the esophagus while the anterior fundus is folded ov the anterior aspect of the gastroesophageal junction. The fundoplication is completed by placing three sutures to fashion circumferential wrap of the stomach around the esophagus just above the gastroesophageal junction. Each suture encompasses a generous bite of the anterior fundic wall, the esophageal musculature, and the retroesophageal posterior fundic wall. The fundoplication is then reduced below the diaphragm into the abdomen. The crural pillars are apposed with 1 to 3 sutures posterior to the esophagus to narrow the hiatus. The dilator is removed, hemostasis is obtained, and the abdominal and thoracic cavities are irrigated with saline. The diaphragmatic incision is closed and the costal arch reconstructed. A chest tube is placed, the lung re-expanded and the thoracoabdominal incision is then closed.

Description of Post-Service Work:
Hospital: Apply sterile dressings. Monitor patient during reversal of anesthesia. Avoidance of sudden straining during extubation is stressed. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia and anti-emetics. 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 ICU and discuss ongoing care with floor nurses. Order x-rays as per routine. Examine patient, including reviewing vital signs and respiratory status. 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 (eg. 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, fami members and discharging nurse. The patient is discharged when there is return of bowel function, adequate nutritiona 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 progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Keith Naunheim, MD, FACS; Francis Nichols, MD, FACS; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS				
Specialty(s):	cardiothoracic surgery; general surgery				
CPT Code:	43336				
Sample Size:	600	**Resp N:**	39	**Response:** 6.5 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	2.00	10.00
Survey RVW:	25.00	31.00	**35.00**	38.50	45.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	120.00	185.00	**240.00**	275.00	360.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 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):	**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:	43336	**Recommended Physician Work RVU: 35.00**		
		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:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**175.00**	99231x **2.00** 99232x **2.00** 99233x **1.00**
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
43632	090	35.14	**RUC Time**

CPT Descriptor Gastrectomy, partial, distal; with gastrojejunostomy

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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:** 33.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 43336**	**Key Reference CPT Code:** 43632	**Source of Time** RUC Time
Median Pre-Service Time	80.00	60.00	
Median Intra-Service Time	240.00	225.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	70.0	70.00	
Median Other Hospital Visit Time	175.0	240.00	
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	**695.00**	**725.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.15	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.23	4.08
Urgency of medical decision making	3.31	3.23
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.46	4.23
Physical effort required	4.54	4.38
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.08	4.15
Outcome depends on the skill and judgment of physician	4.38	4.38
Estimated risk of malpractice suit with poor outcome	3.77	3.54

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.08	3.77
Intra-Service intensity/complexity	4.62	4.23
Post-Service intensity/complexity	3.77	3.54

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.*

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

The change in the work to repair an esophageal hernia over time has resulted in confusion and deficiencies in the coding structure necessitating a revision of the current CPT codes. When the original paraesophageal hernia repair codes were introduced, they were meant to report anatomic defects within the diaphragm. Dr. Allison originated these repairs and emphasized the importance of the diaphragm in the pathophysiology of hiatus hernias (Allison PR, Ann Surg 1973;178:273-6). Thus for many years (in the now distant past), paraesophageal hernias were repaired by simply reducing the hernia contents below the diaphragm and narrowing the diaphragmatic crura with suture to prevent re-herniation. These repairs were performed in an open fashion by either a transabdominal or transthoracic approach. Sometimes tacking sutures were used to fix the stomach to the abdominal wall or occasionally a gastrostomy tube was placed to fix the stomach in place so it would not re-herniate. Occasionally, strictures were dilated or concomitant ulcer disease was treated by vagotomy and pyloroplasty.

Because this was the era prior to modern anti-acid treatment with H2 histamine blockers and PPIs, esophageal strictures requiring treatment were frequent occurrences in paraesophageal hernia patients. In addition, ulcer disease of the stomach and duodenum was also common at that time because H. pylori had not yet been recognized as an etiologic agent. It was therefore frequent to find giant paraesophageal hernias associated with concomitant strictures and/or ulcer disease. For these reasons, the diaphragmatic hernia repair codes were written to include concomitant treatment for strictures (with and without dilation) and ulcer disease (with or without vagotomy and pyloroplasty). However, in 2010, these treatments (dilation, V&P) are virtually never performed concomitant with paraesophageal hernia repair, and thus the codes as written do not reflect current therapy.

Modern investigation has emphasized the importance of the lower esophageal sphincter's ability to generate pressure to prevent gastroesophageal reflux and the need to augment sphincter pressure with fundoplication, typically a 360 degree full wrap (Nissen) or a partial wrap (Belsey, Mark IV, Toupet). With this further understanding of the pathophysiology, these defects have now been reclassified as variants of hiatal hernia. The current coding schema is in direct opposition to this modern classification. The adjunctive surgical procedures of intraoperative dilatation, vagotomy, and pyloroplasty are now virtually never concomitantly performed with paraesophageal hernia repair; however, fundoplasty is almost always performed. Esophageal dilatation, if needed, is now done by gastroenterologists before any surgical procedure.

In summary, the work described by the current (to-be-deleted) codes was intended for patients with reflux/acid (chemical symptoms) or blockage (mechanical symptoms). With the advent of medical management and less invasive treatments, the patients currently undergoing surgery are symptomatic, typically with blockage. The typical patient has more advanced disease and requires more complex repair.

Recommendation – BB7 (43336) and BB8 (43337)
The Society of Thoracic Surgeons and the American College of Surgeons conducted a RUC survey and received 39 responses for BB7 and 33 responses for BB8. Both of these procedures would not be performed often and as such the median experience rate in the past 12 months is low. However, cardiothoracic surgeons and general surgeons are familiar with these procedures. A consensus panel of cardiothoracic surgeons and general surgeons reviewed the survey data and agree that the median intra-operative time of 240 minutes is an accurate reflection of the time to perform BB7. The panel also agrees that the BB8 (with mesh) would reasonably incur an additional 20-30 minutes of time, and accepts the median time of 260. With respect to post-op hospital visits, the panel notes that the patients (both BB7 and BB8) would be transferred to the ICU post-operatively. These patient are very unstable and require ICU attention by the surgeon in excess of 60 minutes on the first day. Both thoracic and abdominal muscular are involved in the procedure and their will significant fluid shifts. Postoperatively, these patients will be on a ventilator and fragile in every sense of ICU care. Therefore, we have indicated one of the hospital visits at 99291 level.

As discussed above in the compelling evidence section, the work and the severity of illness of the patient treated with new codes BB7 and BB8 is significantly greater than the work originally described by 39530 or 39531. New codes BB7 and BB8 will always include fundoplasty in current practice and patients that have typically failed medical management and/or less invasive treatments. Additionally, new code BB8 will add the new work of mesh implantation.

We are recommending the survey median RVW of 35.00 for BB7 and the survey median RVW of 37.10 for BB8. These recommendations are supported by the key reference code 43632. We believe the difference in work for the

implantation of mesh at 1.10 RVWs is understated and probably probably a result of the low frequency at which these procedures are performed.

Pre-time package 4 difficult patient/difficult procedure is appropriate for BB7 and BB8, with additional time for positioning; patient is placed in lateral decubitus position with attention to padding to protect the nerves for the lengthy 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) 39530 or 39531 or 43326

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

Specialty thoracic surgery	How often? Rarely
Specialty cardiac surgery	How often? Rarely
Specialty general surgery	How often? Rarely

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

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 101
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please

explain the rationale for this estimate. BB7 was previously reported with 39530, 39531 or 43326. A review of the frequency for all deleted codes and croswalking to new codes resulted in an estimate of (100% x frequency of 39530 and 39531) plus (5% frequency of 43326) multiplied by 80%. The other 20% would be reported as BB8 - with mesh.

Specialty cardiothoracic surgery Frequency 51 Percentage 50.49 %

Specialty general surgery Frequency 50 Percentage 49.50 %

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? (ie. similar work RVU, and specialty) 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

	SURVEY CODES		APPROACH	Est freq						
BB1	4332X	Nissen	abdominal	1,206	43324	1,121	80% gs	43326	85	40% gs
BB2	4332X1	Nissen	thoracic	302	43324	280	20% cts	43326	21	10% cts
BB3	4332X2	PEH	abdominal	2,169	43326	53	25% gs	39502	2,658	all
BB4	4332X21	PEH w/mesh	abdominal	542	X	434	20% of w/o mesh			
BB5	4332X3	PEH	thoracic	326	43326	21	10% cts	39520	387	all
BB6	4332X31	PEH w/mesh	thoracic	82	X	65	20% of w/o mesh			
BB7	4332X4	PEH	thoro-abdom	101	43326	11	5% any	39530 39531	115	all
BB8	4332X41	PEH w/mesh	thoro-abdom	25	X	20	20% of w/o mesh			
BB9	4332X5	open Collis	open	64	43326	64	30% total			
BB10	4328X	Lap Collis	laparoscopic	80	NEW	80	25% more than open			

X=39599 or 43499 (NEW - with mesh)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43337 Tracking Number BB8 Specialty Society Recommended RVU: **38.40**

Global Period: 090 RUC Recommended RVU: **37.50**

CPT Descriptor: Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old female has undergone two previous antireflux procedures and now presents with recurrent severe substernal burning, nocturnal waterbrash, and dysphagia secondary to a recurrent paraesophageal hernia. Imaging confirms the wrap has broken down and the hernia has recurred. The patient is referred for repeat antireflux surgery.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

ercent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an &M service later on the same day 100%

Moderate Sedation

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

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

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

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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. Review results of preadmission labs and imaging. 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 draped. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: abdominal musculature. The abdomen and chest are entered the inferior pulmonary gament is divided to mobilize the lung and expose the mediastinum. The mediastinal pleura is incised overlying the esophagus from the aortic arch down to the diaphragm. Adhesions surrounding the previously dissected esophagus are carefully taken down and the esophagus is mobilized circumferentially beginning immediately under the arch and extending down to the gastroesophageal junction. The diaphragm is incised and taken down off the chest wall circumferentially. The subdiaphragmatic adhesions, which fix the gastric body to the liver and crura and prevent reduction

of the stomach into the abdomen, are than carefully dissected. A 56 French esophageal dilator is advanced into the esophagus by the anesthesiologist so that it can be used to appropriately "size" the crural repair and fundoplication. The gastroesophageal junction is reduced 3 cms into the abdomen. If this cannot be accomplished a lengthening procedure is performed (reported separately). The posterior fundic wall is then brought posterior to the esophagus while the anterior fundus is folded over the anterior aspect of the gastroesophageal junction. The fundoplication is completed by placing thre sutures to fashion a circumferential wrap of the stomach around the esophagus just above the gastroesophageal junctio Each suture encompasses a generous bite of the anterior fundic wall, the esophageal musculature, and the retroesophageal posterior fundic wall. The fundoplication is then reduced below the diaphragm into the abdomen. The hiatus is very large and of poor quality and the surgeon decides that mesh repair of the diaphragm is required. Mesh repair and reinforcement of the diaphragmatic crura is performed. The dilator is removed, hemostasis is obtained, and the abdominal and thoracic cavities are irrigated with saline. The diaphragmatic incision is closed and the costal arch reconstructed. A chest tube is placed, the lung re-expanded and the thoracoabdominal incision is then closed.

Description of Post-Service Work:
Hospital: Apply sterile dressings. Monitor patient during reversal of anesthesia. Avoidance of sudden straining during extubation is stressed. Discuss postoperative recovery care with anesthesia and nursing staff including need for patient controlled analgesia and anti-emetics. 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 ICU and discuss ongoing care with floor nurses. Order x-rays as per routine. Examine patient, including reviewing vital signs and respiratory status. 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 (eg. 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, fami 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 progress notes for medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Keith Naunheim, MD, FACS; Francis Nichols, MD, FACS; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS				
Specialty(s):	cardiothoracic surgery; general surgery				
CPT Code:	43337				
Sample Size:	600	**Resp N:**	39	**Response:** 6.5 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	1.00	10.00
Survey RVW:	27.00	34.75	**36.10**	42.00	45.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	150.00	220.00	**240.00**	300.00	405.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**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):	**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:	43337	**Recommended Physician Work RVU: 37.50**		
		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:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**260.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**175.00**	99231x **2.00** 99232x **2.00** 99233x **1.00**
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
43632	090	35.14	**RUC Time**

CPT Descriptor Gastrectomy, partial, distal; with gastrojejunostomy

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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:** 20.5 %

TIME ESTIMATES (Median)	CPT Code: 43337	Key Reference CPT Code: 43632	Source of Time RUC Time
Median Pre-Service Time	80.00	60.00	
Median Intra-Service Time	260.00	225.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	70.0	70.00	
Median Other Hospital Visit Time	175.0	240.00	
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	**715.00**	**725.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.13	3.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.13	3.86
Urgency of medical decision making	3.38	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.38	4.00
Physical effort required	4.38	4.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.88	3.86
Outcome depends on the skill and judgment of physician	3.88	3.71
Estimated risk of malpractice suit with poor outcome	3.63	3.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.25	3.57
Intra-Service intensity/complexity	4.50	4.17
Post-Service intensity/complexity	3.63	3.14

Additional Rationale and Comments

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

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

The change in the work to repair an esophageal hernia over time has resulted in confusion and deficiencies in the coding structure necessitating a revision of the current CPT codes. When the original paraesophageal hernia repair codes were introduced, they were meant to report anatomic defects within the diaphragm. Dr. Allison originated these repairs and emphasized the importance of the diaphragm in the pathophysiology of hiatus hernias (Allison PR, Ann Surg 1973;178:273-6). Thus for many years (in the now distant past), paraesophageal hernias were repaired by simply reducing the hernia contents below the diaphragm and narrowing the diaphragmatic crura with suture to prevent re-herniation. These repairs were performed in an open fashion by either a transabdominal or transthoracic approach. Sometimes tacking sutures were used to fix the stomach to the abdominal wall or occasionally a gastrostomy tube was placed to fix the stomach in place so it would not re-herniate. Occasionally, strictures were dilated or concomitant ulcer disease was treated by vagotomy and pyloroplasty.

Because this was the era prior to modern anti-acid treatment with H2 histamine blockers and PPIs, esophageal strictures requiring treatment were frequent occurrences in paraesophageal hernia patients. In addition, ulcer disease of the stomach and duodenum was also common at that time because H. pylori had not yet been recognized as an etiologic agent. It was therefore frequent to find giant paraesophageal hernias associated with concomitant strictures and/or ulcer disease. For these reasons, the diaphragmatic hernia repair codes were written to include concomitant treatment for strictures (with and without dilation) and ulcer disease (with or without vagotomy and pyloroplasty). However, in 2010, these treatments (dilation, V&P) are virtually never performed concomitant with paraesophageal hernia repair, and thus the codes as written do not reflect current therapy.

Modern investigation has emphasized the importance of the lower esophageal sphincter's ability to generate pressure to prevent gastroesophageal reflux and the need to augment sphincter pressure with fundoplication, typically a 360 degree full wrap (Nissen) or a partial wrap (Belsey, Mark IV, Toupet). With this further understanding of the pathophysiology, these defects have now been reclassified as variants of hiatal hernia. The current coding schema is in direct opposition to this modern classification. The adjunctive surgical procedures of intraoperative dilatation, vagotomy, and pyloroplasty are now virtually never concomitantly performed with paraesophageal hernia repair; however, fundoplasty is almost always performed. Esophageal dilatation, if needed, is now done by gastroenterologists before any surgical procedure.

In summary, the work described by the current (to-be-deleted) codes was intended for patients with reflux/acid (chemical symptoms) or blockage (mechanical symptoms). With the advent of medical management and less invasive treatments, the patients currently undergoing surgery are symptomatic, typically with blockage. The typical patient has more advanced disease and requires more complex repair.

Recommendation – BB7 (43336) and BB8 (43337)
The Society of Thoracic Surgeons and the American College of Surgeons conducted a RUC survey and received 39 responses for BB7 and 33 responses for BB8. Both of these procedures would not be performed often and as such the median experience rate in the past 12 months is low. However, cardiothoracic surgeons and general surgeons are familiar with these procedures. A consensus panel of cardiothoracic surgeons and general surgeons reviewed the survey data and agree that the median intra-operative time of 240 minutes is an accurate reflection of the time to perform BB7. The panel also agrees that BB8 (with mesh) would reasonably incur an additional 20-30 minutes of time, those with experience had a median time of 260, although the overall median for all responding was 240. With respect to post-op hospital visits, the panel notes that the patients (both BB7 and BB8) would be transferred to the ICU post-operatively. These patient are very unstable and require ICU attention by the surgeon in excess of 60 minutes on the first day. Both thoracic and abdominal muscular are involved in the procedure and their will significant fluid shifts. Postoperatively, these patients will be on a ventilator and fragile in every sense of ICU care. Therefore, we have indicated one of the hospital visits at 99291 level.

As discussed above in the compelling evidence section, the work and the severity of illness of the patient treated with new codes BB7 and BB8 is significantly greater than the work originally described by 39530 or 39531. New codes BB7 and BB8 will always include fundoplasty in current practice and patients that have typically failed medical management and/or less invasive treatments. Additionally, new code BB8 will add the new work of mesh implantation.

We are recommending the survey median RVW of 35.00 for BB7 and the survey median RVW of 37.50 for BB8. These recommendations are supported by the key reference code 43632. We believe the difference in work for the implantation of mesh at 1.10 RVWs is understated and probably a result of the low frequency at which these procedures are performed.

Pre-time package 4 difficult patient/difficult procedure is appropriate for BB7 and BB8, with additional time for positioning; patient is placed in lateral decubitus position with attention to padding to protect the nerves for the lengthy 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) 39599 or 43499

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

Specialty thoracic surgery	How often? Rarely
Specialty cardiac surgery	How often? Rarely
Specialty general surgery	How often? Rarely

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

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 25 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. BB4 was previously reported with unlisted codes. This estimate is based on consideration of the frequency for BB7.

Specialty cardiothoracic surgery Frequency 13 Percentage 52.00 %

Specialty general surgery Frequency 12 Percentage 48.00 %

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? (ie. similar work RVU, and specialty) 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

	SURVEY CODES		APPROACH	Est freq						
BB1	4332X	Nissen	abdominal	1,206	43324	1,121	80% gs	43326	85	40% gs
BB2	4332X1	Nissen	thoracic	302	43324	280	20% cts	43326	21	10% cts
BB3	4332X2	PEH	abdominal	2,169	43326	53	25% gs	39502	2,658	all
BB4	4332X21	PEH w/mesh	abdominal	542	X	434	20% of w/o mesh			
BB5	4332X3	PEH	thoracic	326	43326	21	10% cts	39520	387	all
BB6	4332X31	PEH w/mesh	thoracic	82	X	65	20% of w/o mesh			
BB7	4332X4	PEH	thoro-abdom	101	43326	11	5% any	39530 39531	115	all
BB8	4332X41	PEH w/mesh	thoro-abdom	25	X	20	20% of w/o mesh			
BB9	4332X5	open Collis	open	64	43326	64	30% total			
BB10	4328X	Lap Collis	laparoscopic	80	NEW	80	25% more than open			

X=39599 or 43499 (NEW - with mesh)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43338 Tracking Number BB9 Specialty Society Recommended RVU: **3.00**

Global Period: ZZZ RUC Recommended RVU: **3.00**

CPT Descriptor: Esophageal lengthening procedure (eg Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for basic service)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female, while undergoing open repair of a paraesophageal hiatal hernia, is found to have a foreshortened esophagus and the gastroesophageal junction cannot be reduced into the abdomen. [Please note this is an add-on code. For this survey, only consider the additional physician work related to the esophageal lengthening procedure.]

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

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

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

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

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

Moderate Sedation

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

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

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

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Description of Pre-Service Work: N/A

Description of Intra-Service Work: Once it is established that the gastroesophageal junction will not reduce 3 cms below the hiatus without tension, a Collis or wedge gastroplasty is performed to "lengthen" the esophagus by creating a new or "neoesophagus" out of a 2 to 4 cm length of the stomach along the lesser curve. This entails stapling of the fundus immediately adjacent to the esophagus into which a dilator has been placed to "size" the neoesophagus. The Collis gastroplasty or wedge resection is completed and the fundoplication performed over the neoesophagus.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Keith Naunheim, MD, FACS; Francis Nichols, MD, FACS; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS				
Specialty(s):	cardiothoracic surgery; general surgery				
CPT Code:	43338				
Sample Size:	600	**Resp N:** 43	**Response:** 7.1 %		
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	3.00	50.00
Survey RVW:	3.00	4.50	**5.00**	6.47	10.00
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	30.00	**30.00**	43.00	60.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
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: ZZZ Global Code

CPT Code:	43338	**Recommended Physician Work RVU: 3.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**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
44121	ZZZ	4.44	**RUC Time**

CPT Descriptor Gastrectomy, partial, distal; with gastrojejunostomy

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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:** 30.2 %

TIME ESTIMATES (Median)	**CPT Code: 43338**	**Key Reference CPT Code: 44121**	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	60.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**30.00**	**60.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.54
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	2.54
Urgency of medical decision making	3.15	2.54
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.92	3.00
Physical effort required	3.38	2.85
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.69	3.23
Outcome depends on the skill and judgment of physician	4.00	3.23
Estimated risk of malpractice suit with poor outcome	3.54	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.62	2.62
Intra-Service intensity/complexity	3.77	3.00
Post-Service intensity/complexity	2.85	2.92

Additional Rationale and Comments

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

Compelling Evidence

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

The change in the work to repair an esophageal hernia over time has resulted in confusion and deficiencies in the coding structure necessitating a revision of the current CPT codes. When the original paraesophageal hernia repair codes were introduced, they were meant to report anatomic defects within the diaphragm. Dr. Allison originated these repairs and emphasized the importance of the diaphragm in the pathophysiology of hiatus hernias (Allison PR, Ann Surg 1973;178:273-6). Thus for many years (in the now distant past), paraesophageal hernias were repaired by simply reducing the hernia contents below the diaphragm and narrowing the diaphragmatic crura with suture to prevent re-herniation. These repairs were performed in an open fashion by either a transabdominal or transthoracic approach. Sometimes tacking sutures were used to fix the stomach to the abdominal wall or occasionally a gastrostomy tube was placed to fix the stomach in place so it would not re-herniate. Occasionally, strictures were dilated or concomitant ulcer disease was treated by vagotomy and pyloroplasty.

Because this was the era prior to modern anti-acid treatment with H2 histamine blockers and PPIs, esophageal strictures requiring treatment were frequent occurrences in paraesophageal hernia patients. In addition, ulcer disease of the stomach and duodenum was also common at that time because H. pylori had not yet been recognized as an etiologic agent. It was therefore frequent to find giant paraesophageal hernias associated with concomitant strictures and/or ulcer disease. For these reasons, the diaphragmatic hernia repair codes were written to include concomitant treatment for strictures (with and without dilation) and ulcer disease (with or without vagotomy and pyloroplasty). However, in 2010, these treatments (dilation, V&P) are virtually never performed concomitant with paraesophageal hernia repair, and thus the codes as written do not reflect current therapy.

Modern investigation has emphasized the importance of the lower esophageal sphincter's ability to generate pressure to prevent gastroesophageal reflux and the need to augment sphincter pressure with fundoplication, typically a 360 degree full wrap (Nissen) or a partial wrap (Belsey, Mark IV, Toupet). With this further understanding of the pathophysiology, these defects have now been reclassified as variants of hiatal hernia. The current coding schema is in direct opposition to this modern classification. The adjunctive surgical procedures of intraoperative dilatation, vagotomy, and pyloroplasty are now virtually never concomitantly performed with paraesophageal hernia repair; however, fundoplasty is almost always performed. Esophageal dilatation, if needed, is now done by gastroenterologists before any surgical procedure.

In summary, the work described by the current (to-be-deleted) codes was intended for patients with reflux/acid (chemical symptoms) or blockage (mechanical symptoms). With the advent of medical management and less invasive treatments, the patients currently undergoing surgery are symptomatic, typically with blockage. The typical patient has more advanced disease and requires more complex repair.

Recommendation – BB9 (43338) and BB10 (43283)

The STS and ACS conducted a RUC survey and received 43 responses for both BB9 and BB10. A consensus panel of cardiothoracic surgeons and general surgeons reviewed the survey data and agree that the median intra-operative time of 30 minutes is an accurate reflection of the time to perform BB9. The panel also agrees that BB10 (laparoscopic approach) would reasonably incur an additional 10 minutes of time, and agrees with the median time of 40 minutes.

As discussed above in the compelling evidence section, the performance of esophageal lengthening procedures area currently performed in order to successfully relocate within the abdominal cavity, in a tension-free fashion, the displaced gastroesophageal junction. The frequency of these procedures will be low; less than 200 annually for both approaches in the Medicare population.

We are recommending the **an RVW of 3.00 for BB9** and an RVW of 4.00 for BB10. These values are less than the survey 25th percentile RVW. The resulting intensity of these recommendations is 0.100 which is consistent with or less than the intensity of the primary procedures BB1-BB8 and consistent with the intensity of other ZZZ add-on codes, including the following ZZZ MPC codes:

CPT	DESC	IWPUT	TOT TIME
60512	Autotransplant parathyroid	0.099	45
22525	Percutaneous kyphoplasty	0.112	40
35600	Harvest artery for CABG	0.124	40
63295	Repair laminectomy defect	0.112	55

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each 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) 39599 or 43499

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

Specialty thoracic surgery How often? Sometimes

Specialty cardiac 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?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Not able to estimate national frequency

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 64 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 30% of codes previously reported with 43326 would require an esophageal lengthening procedure.

Specialty cardiothoracic surgery Frequency 32 Percentage 50.00 %

Specialty general surgery Frequency 32 Percentage 50.00 %

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 43219

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:43283 Tracking Number BB10 Specialty Society Recommended RVU: **4.00**

Global Period: ZZZ RUC Recommended RVU: **4.00**

CPT Descriptor: Laparoscopy, surgical, esophageal lengthening procedure (eg Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for basic service)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male, while undergoing laparoscopic repair of a paraesophageal hiatal hernia, is found to have a foreshortened esophagus and the gastroesophageal junction cannot be reduced into the abdomen. [Please note this is an add-on code. For this survey, only consider the additional physician work related to the esophageal lengthening procedure.]

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

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

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

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Once it is established that the gastroesophageal junction will not reduce 3 cms below the hiatus without tension, a laparoscopic Collis gastroplasty or wedge is performed to "lengthen" the esophagus by creating a new or "neoesophagus" out of a 2 to 4 cm length of the stomach along the lesser curve. This entails stapling, via laparoscopy, of the fundus immediately adjacent to the esophagus into which a dilator has been placed to "size" the neoesophagus. The laparoscopic Collis gastroplasty or wedge resection is completed and the fundoplication performed over the neoesophagus.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Keith Naunheim, MD, FACS; Francis Nichols, MD, FACS; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS				
Specialty(s):	cardiothoracic surgery; general surgery				
CPT Code:	43283				
Sample Size:	600	**Resp N:**	43	**Response:** 7.1 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	4.00	25.00
Survey RVW:	3.50	4.80	**5.20**	6.50	10.00
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	30.00	**40.00**	45.00	80.00

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: ZZZ Global Code

CPT Code:	43283	**Recommended Physician Work RVU: 4.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**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? 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
44121	ZZZ	4.44	**RUC Time**

CPT Descriptor Enterectomy, resection of small intestine; each additional resection and anastomosis (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
		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:** 25.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 43283**	**Key Reference CPT Code:** 44121	**Source of Time** RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	40.00	60.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**40.00**	**60.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.64	2.18
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.73	2.55
Urgency of medical decision making	2.64	2.55
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	3.27
Physical effort required	3.45	2.91
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.36	3.00
Outcome depends on the skill and judgment of physician	3.64	3.09
`stimated risk of malpractice suit with poor outcome	3.09	2.73

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.91	2.73
Intra-Service intensity/complexity	3.82	3.45
Post-Service intensity/complexity	3.00	3.00

Additional Rationale and Comments

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

Compelling Evidence

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

The change in the work to repair an esophageal hernia over time has resulted in confusion and deficiencies in the coding structure necessitating a revision of the current CPT codes. When the original paraesophageal hernia repair codes were introduced, they were meant to report anatomic defects within the diaphragm. Dr. Allison originated these repairs and emphasized the importance of the diaphragm in the pathophysiology of hiatus hernias (Allison PR, Ann Surg 1973;178:273-6). Thus for many years (in the now distant past), paraesophageal hernias were repaired by simply reducing the hernia contents below the diaphragm and narrowing the diaphragmatic crura with suture to prevent re-herniation. These repairs were performed in an open fashion by either a transabdominal or transthoracic approach. Sometimes tacking sutures were used to fix the stomach to the abdominal wall or occasionally a gastrostomy tube was placed to fix the stomach in place so it would not re-herniate. Occasionally, strictures were dilated or concomitant ulcer disease was treated by vagotomy and pyloroplasty.

Because this was the era prior to modern anti-acid treatment with H2 histamine blockers and PPIs, esophageal strictures requiring treatment were frequent occurrences in paraesophageal hernia patients. In addition, ulcer disease of the stomach and duodenum was also common at that time because H. pylori had not yet been recognized as an etiologic agent. It was therefore frequent to find giant paraesophageal hernias associated with concomitant strictures and/or ulcer disease. For these reasons, the diaphragmatic hernia repair codes were written to include concomitant treatment for strictures (with and without dilation) and ulcer disease (with or without vagotomy and pyloroplasty). However, in 2010, these treatments (dilation, V&P) are virtually never performed concomitant with paraesophageal hernia repair, and thus the codes as written do not reflect current therapy.

Modern investigation has emphasized the importance of the lower esophageal sphincter's ability to generate pressure to prevent gastroesophageal reflux and the need to augment sphincter pressure with fundoplication, typically a 360 degree full wrap (Nissen) or a partial wrap (Belsey, Mark IV, Toupet). With this further understanding of the pathophysiology, these defects have now been reclassified as variants of hiatal hernia. The current coding schema is in direct opposition to this modern classification. The adjunctive surgical procedures of intraoperative dilatation, vagotomy, and pyloroplasty are now virtually never concomitantly performed with paraesophageal hernia repair; however, fundoplasty is almost always performed. Esophageal dilatation, if needed, is now done by gastroenterologists before any surgical procedure.

In summary, the work described by the current (to-be-deleted) codes was intended for patients with reflux/acid (chemical symptoms) or blockage (mechanical symptoms). With the advent of medical management and less invasive treatments, the patients currently undergoing surgery are symptomatic, typically with blockage. The typical patient has more advanced disease and requires more complex repair.

Recommendation – BB9 (43338) and BB10 (43283)

The STS and ACS conducted a RUC survey and received 43 responses for both BB9 and BB10. A consensus panel of cardiothoracic surgeons and general surgeons reviewed the survey data and agree that the median intra-operative time of 30 minutes is an accurate reflection of the time to perform BB9. The panel also agrees that BB10 (laparoscopic approach) would reasonably incur an additional 10 minutes of time, and agrees with the median time of 40 minutes.

As discussed above in the compelling evidence section, the performance of esophageal lengthening procedures area currently performed in order to successfully relocate within the abdominal cavity, in a tension-free fashion, the displaced gastroesophageal junction. The frequency of these procedures will be low; less than 200 annually for both approaches in the Medicare population.

We are recommending the an RVW of 3.00 for BB9 and an **RVW of 4.00 for BB10**. These values are less than the survey 25th percentile RVW. The resulting intensity of these recommendations is 0.100 which is consistent with or less than the intensity of the primary procedures BB1-BB8 and consistent with the intensity of other ZZZ add-on codes, including the following ZZZ MPC codes:

CPT	DESC	IWPUT	TOT TIME
60512	Autotransplant parathyroid	0.099	45
22525	Percutaneous kyphoplasty	0.112	40
35600	Harvest artery for CABG	0.124	40
63295	Repair laminectomy defect	0.112	55

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.

FREQUENCY INFORMATION

low was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 43289

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

Specialty thoracic surgery	How often? Rarely
Specialty cardiac surgery	How often? Rarely
Specialty general surgery	How often? Rarely

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

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

stimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 80 If is 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 125% of the estimate for the open code BB9.

Specialty general surgery	Frequency 60	Percentage 75.00 %

Specialty cardiothoracic surgery Frequency 20 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? (ie. similar work RVU, and specialty) Yes

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

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

	A	B	C	D	E	F	G	H	I	J	K		M
1	AMA/Specialty Society RVS Update Committee Recommendation			BB1	BB2	BB3	BB4	BB5	BB6	BB7	BB8	BB9	BB10
2	Meeting Date: April 2010			43327	43328	43332	4333	43334	43335	43336	43337	43338	43283
3				Esophagogastric fundoplasty partial or	Esophagogastric fundoplasty partial or	Repair, paraesophageal hiatal hernia	Repair, paraesophageal hiatal hernia	Repair, paraesophageal hiatal hernia	Repair, paraesophageal hiatal hernia	Repair, paraesophageal hiatal hernia,	Repair, paraesophageal hiatal hernia,	Esophageal lengthening procedure (eg Collis	Laparoscopy, surgical, esophageal lengthening
4	**LOCATION**	**Code**	**Staff Type**	**FAC**	**FAC**	**FAC**	**FAC**	**FAC**	**FAC**	**FAC**	**FAC**	**FAC**	**FAC**
5	GLOBAL PERIOD			**90**	**90**	**90**	**90**	**90**	**90**	**90**	**90**	**ZZZ**	**ZZZ**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**144**	**144**	**144**	**144**	**144**	**144**	**171**	**171**	**0**	**0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**60**	**0**	**0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**0**	**0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**72**	**72**	**72**	**72**	**72**	**72**	**99**	**99**	**0**	**0**
10	**PRE-SERVICE**												
11	**Start: Following visit when decision for surgery or procedure made**												
12	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**0**	**0**
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**0**	**0**
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**0**	**0**
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**0**	**0**
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**0**	**0**
17	Other Clinical Activity (please specify)	**L037D**	RN/LPN/MTA										
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**												
38	Discharge day management	**L037D**	RN/LPN/MTA	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**		
40	**End: Patient leaves office**												
41	**POST-SERVICE Period**												
42	**Start: Patient leaves office/facility**												
43	Conduct phone calls/call in prescriptions												
44	*Office visits.*												
45	*List Number and Level of Office Visits*												
46	99211 16 minutes		16										
47	99212 27 minutes		27							**1**	**1**		
48	99213 36 minutes		36	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**		
49	99214 53 minutes		53										
50	99215 63 minutes		63										
51	Other												
52	***Total Office Visit Time***	**L037D**	RN/LPN/MTA	**72**	**72**	**72**	**72**	**72**	**72**	**99**	**99**	**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**	**2**	**2**	**2**	**2**	**2**	**2**	**3**	**3**		
57	pack, post-op incision care (suture & staple)	**SA053**	**pack**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**		
58	**Equipment**	**Code**											
59	table, power	**EF031**		**72**	**72**	**72**	**72**	**72**	**72**	**99**	**99**		
60	light, surgical	**EF014**		**72**	**72**	**72**	**72**	**72**	**72**	**99**	**99**		

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2010

Gastric Intubation

In October 2009, the CPT Editorial Panel deleted 11 low volume CPT codes and created 5 new codes to clarify, update, and simplify the gastric intubation services involving enteric tubes being passed to collect specimens of gastric or duodenal fluid for analysis.

43753 Gastric intubation and aspiration(s), therapeutic (eg, gastrointestinal hemorrage), including lavage if performed
Code 43753 was modified and renumbered from deleted code 91105 *Gastric intubation, and aspiration or lavage for treatment (eg, for ingested poisons)* (Work RVU = 0.37, 000 global) by the CPT Editorial Panel. Survey data from 39 emergency medicine physicians who have had experience performing this service were collected. The specialty survey results indicated that this service was undervalued as the survey median work relative value was 1.30 and total physician time was 24 minutes as compared to its current total service time of 16 minutes. The RUC and the specialty society acknowledged that the procedure will typically be reported with an E/M service and believed some reduction in the pre-service time and physician work value, from the survey results, was appropriate. The RUC agreed with the specialty society's that the typical patient is now one who has a gastrointestinal hemorrhage rather than one who ingested poisons. The RUC also agreed that there was compelling evidence that the service had been reviewed by Harvard at a time when emergency medicine was not a recognized Medicare specialty. The RUC reviewed the survey's key reference service CPT code 31575 *Laryngoscopy; flexible fiberoptic; diagnostic* (Work RVU = 1.10, Total physician time = 25 minutes, 000 global), and 29075 *Application, cast; elbow to finger (short arm)* (Work RVU = 0.77, Total physician time = 25 minutes, 000 global) in relation to new code 43753. The RUC concluded that the pre-service evaluation physician time (3 minutes) should be extracted from the surveyed time and that the intra-service time of 10 minutes and immediate post time of 5 minutes adequately reflected the time it required to perform the service. Total time consisting of pre-service time of 6 minutes, 10 minutes intra-service, and 5 minutes immediate post service, was accepted. The RUC agreed that the value of 43753 is very similar to new service 43754 *Gastric intubation and aspiration, diagnostic; single specimen (eg, acid analysis)* (RUC recommended Work RVU of 0.45) and was similar to a code renumbered from code 89130 *Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology* (work RVU = 0.45) as therapeutic gastric intubation should be valued no lower. Lastly, the RUC compared the work of 43753 to CPT code 99212 *established office visit code* (work RVU = 0.48) and agreed that the work, time, and intensities were similar. **The RUC recommends a relative work value of 0.45 for CPT code 43753.**

43754 Gastric intubation and aspiration, diagnostic; single specimen (eg, acid analysis)

New code 43754 was modified and renumbered from deleted code 89130 *Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology;* (Work RVU = 0.45, XXX global). The specialty society's survey response rate was low as the performance of these services is estimated to be 470 in the Medicare population. Given the small number of physicians who perform this service and the wide variation in survey response, the median service performance rate was zero, the specialty societies and RUC agreed that there was no compelling reason to change the work relative value of 43754 from the virtually identical service 89130. The physician work for this service involves patient evaluation and the supervision of the specimen collection and its assessment. The RUC reviewed the physician work of existing code 89130 and the work of CPT code 99212 *established office visit code* (work RVU = 0.48) in relation to this service, and agreed that the relative work value should remain at 0.45. **The RUC recommends a relative work value of 0.45 for CPT code 43754.**

43755 Gastric intubation and aspiration, diagnostic; collection of multiple fractional specimens with gastric stimulation, single or double lumen tube (gastric secretory study) (eg, histamine, insulin, pentagastrin, calcium, secretin)
The specialty survey response rate was low as the performance of these services is estimated to be 40 in the Medicare population. The RUC also agreed that 13 minutes of pre-service time was excessive and recommends 7 minutes to account for the physician time to ensure that the appropriate intravenous medication was being used for gastric stimulation. The RUC agreed that the appropriate physician time components should be 7 minutes pre-service, 25 minutes intra-service, and 5 minutes immediate post service. The RUC agreed that the survey's key reference service, CPT code 91038 *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* (Work RVU = 1.10, Total physician time = 41 minutes, 000 global), requires more total time and intensity compared to the surveyed service. The RUC agreed that the physician work value was quite similar to that the code it replaces, 89140 *Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); 2 hours including gastric stimulation (eg, histalog, pentagastrin)* (Work RVU = 0.94, 30 minutes total physician time, XXX global). **The RUC recommends a relative work value of 0.94 for CPT code 43755.**

43756 Duodenal intubation and aspiration, diagnostic; single specimen (eg, bile study for crystals or afferent loop culture)
New code 43755 represents and is currently reported as a combination of two services: 89100 *Duodenal intubation and aspiration; single specimen (eg, simple bile study or afferent loop culture) plus appropriate test procedure* (Work RVU = 0.60, 20 minutes total physician time, XXX global) and 76000 *Fluoroscopy (separate procedure), up to 1 hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)* (work RVU = 0.17, 5 minutes total physician time). The sum of these work values is 0.77. Given the small number of physicians who perform this service, the small response rate, and the wide variation in the responses, the specialty and the RUC could not identify a compelling reason for the work RVU of new code 43756 to change in comparison to the existing code (89100 + 76000), the sum of which is 0.77. The RUC recognized that the use of fluoroscopy was an inherent component of this service and that a new paragraph in CPT should be made to assist users of CPT. The RUC also noted that code 43752 *Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)*

(Work RVU = 0.81, 30 minutes total physician time, 000 global) is an appropriate comparator to the physician work and intensity of code 43756. **The RUC recommends maintaining a work relative value of 0.77 for CPT code 43756.**

43757 Duodenal intubation and aspiration, diagnostic; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube

New code 43757 represents and is currently reported as a combination of two services: 89105 *Duodenal intubation and aspiration; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube* (Work RVU = 0.50, 17 minutes of physician time, XXX global), and code 76000 *Fluoroscopy (separate procedure), up to 1 hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)* (Work RVU = 0.17, 5 minute of physician time, as fluoroscopy is used to position the tube. The sum of these two distinct services is 0.67 work RVUs, which represents an anomaly when compared to existing code 89100 (work RVU = 0.60), now captured within code 43756, which is placement of a duodenal tube and aspiration of a single specimen. For this reason, the RUC agreed there was compelling evidence to change the current valuation, and provide proper rank order among this CPT family. The RUC also recognized that the use of fluoroscopy was an inherent component of this service and that a new parenthetical in the CPT introductory language should be made to assist users of this service.

The RUC compared the physician work of 43757 to representative services performed by a physician. The RUC agreed that the work of the key reference service, 91022 *Duodenal motility (manometric) study* (work RVU = 1.44), was not an appropriate comparison in terms of the physician work due to the differences in analyzing the data from the tube studies. The specialty and the RUC agreed that the pre-time recommendations of 24 minutes were not representative, and recommended a pre-time of 7 minutes, consistent with the recommended pre-time for code 43755. The RUC reviewed the work of code 43752, *Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)*, (work RVU = 0.81, 5/20/5, 000 global), and understood that the physician work and intensity of code 43757 was higher. The RUC noted that there was additional physician work in code 43757 compared to 43756, as the physician personally administered the intravenous agent, monitored the patient's response to the agent, performed the initial aspirations of duodenal secretions for the first 15 minutes, and was responsible for maintaining the proper position of the tube for the duration of the study. The RUC noted that while code 43752 describes placement of a naso- or oro-gastric tube requiring physician skill, code 43757 required placement beyond the stomach and included sampling of duodenal gastric contents, evaluation of the procedure findings, and generation of management recommendations to the referring physician which would not be captured by any other procedure or E/M service on the date of service. With this understanding, the RUC agreed that the work value of 43757 involves the work of 43756 (0.77) and the difference in work between 43755 and 43754 (0.94 – 0.45 = 0.49). The summation of all this physician work equals 1.26 work RVUs. **The RUC recommends a relative work value of 1.26 for CPT code 43757.**

Practice Expense: The RUC reviewed the direct practice expense inputs for this family of codes and recognized that there would be no direct inputs associated with code 43753, as it is performed in the facility setting. The RUC also made adjustments to the typical medical supplies and equipment for 43754 – 57 for the typical patient encounter.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 43600		Biopsy of stomach; by capsule, tube, peroral (1 or more specimens) (43600 has been deleted)	000	N/A
43605		Biopsy of stomach, by laparotomy	090	13.72
●43753	M1	Gastric intubation and aspiration(s) therapeutic, necessitating physician's skill, not to be used for gastric intubation (eg, for gastrointestinal hemorrhage), including lavage if performed	000	0.45
●43754	M2	Gastric intubation and aspiration, diagnostic; single specimen (eg, acid analysis)	000	0.45
●43755	M3	collection of multiple fractional specimens with gastric stimulation, single or double lumen tube (gastric secretory study) (eg, histamine, insulin, pentagastrin, calcium, secretin), includes drug administration (For gastric acid analysis, use 82930) (For naso- or oro-gastric tube placement by physician with fluoroscopic guidance, use 43752) (Report the drug or substance administered. The fluid used to administer the drug(s) is not separately reported.)	000	0.94

226

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●43756	M4	Duodenal intubation and aspiration, diagnostic, includes image guidance; single specimen (eg, bile study for crystals or afferent loop culture)	000	0.77
●43757	M5	collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube, includes drug administration For appropriate chemical analysis procedures, see 89049-89240) (Report the substances(s) or drug(s). The fluid used to administer the drug(s) is not separately reportable)	000	1.26
Pathology and Laboratory Drug Screening Chemistry				
D 82926		~~Gastric acid, free and total, each specimen~~	XXX	N/A
D 82928		~~Gastric acid, free or total, each specimen~~ (82926, 82928 have been deleted) (For gastric acid analysis, use 82930)	XXX	N/A
●82930		Gastric acid analysis, includes pH if performed, each specimen	XXX	Paid for on the Clinical Lab Fee Schedule
D 89100		~~Duodenal intubation and aspiration; single specimen (eg, simple bile study or afferent loop culture) plus appropriate test procedure~~	XXX	N/A

227

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 89105		~~collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube~~ ~~(For radiological localization, use 74340)~~ ~~(For chemical analyses, see Chemistry, this section)~~ ~~(Electrocardiogram, see 93000-93268)~~ ~~(Esophagus acid perfusion test (Bernstein), see 91030)~~ (89100, 89105 have been deleted. To report, see 43756, 43757)	XXX	N/A
D 89130		~~Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology;~~	XXX	N/A
D 89132		~~after stimulation~~	XXX	N/A
D 89135		~~Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); one hour~~	XXX	N/A
D 89136		~~two hours~~	XXX	N/A
D 89140		~~two hours including gastric stimulation (eg, histalog, pentagastrin)~~	XXX	N/A
D 89141		~~three hours, including gastric stimulation~~ (89130-89141 have been deleted. To report, see 43754, 43755)	XXX	N/A
D 89225		~~Starch granules, feces~~ (89225 has been deleted)	XXX	N/A
D 89235		~~Water load test~~ (89235 has been deleted)	XXX	N/A
D 91000		~~Esophageal intubation and collection of washings for cytology, including~~		N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		~~preparation of specimens (separate procedure)~~ (91000 has been deleted)		
D 91123		~~Pulsed irrigation of fecal impaction~~ (91123 has been deleted)		N/A
D 91052		~~Gastric analysis test with injection of stimulant of gastric secretion (eg, histamine, insulin, pentagastrin, calcium and secretin)~~ ~~(For gastric biopsy by capsule, peroral, via tube, one or more specimens, use 43600)~~ ~~(For gastric laboratory procedures, see also 89130-89141)~~	000	N/A
D 91055		~~Gastric intubation, washings, and preparing slides for cytology (separate procedure)~~ ~~(For gastric lavage, therapeutic, use 91105)~~ ~~(91060 has been deleted)~~ ~~(For biopsy by capsule, small intestine, per oral, via tube [one or more specimens], use 44100)~~ (91052, 91055 have been deleted. To report, see 43754, 43755)	000	N/A
D 91105		~~Gastric intubation and aspiration(s), therapeutic, (eg for ingested poisons), includinglavage if performed~~ (91105 has been deleted. To report, use 43753) ***(For cholangiography, see 47500, 74320)***	000	N/A

229

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43753 Tracking Number M1 Specialty Society Recommended RVU: **0.45**
Global Period: 000 RUC Recommended RVU: **0.45**

CPT Descriptor: Gastric intubation and aspiration(s) therapeutic, necessitating physician's skill, not to be used for gastric intubation (eg, for gastrointestinal hemorrhage), including lavage if performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old male alcoholic presents with a history of coffee-ground bloody emesis for 3 days. He is tachycardic but normotensive. A gastric tube is placed to wall suction and reveals 1 liter of blood-tinged fluid.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 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? 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: Evaluation of the patient's clinical condition, hemodynamics and assessment of nasal or oropharnygeal anatomy. Equipment needed for gastric intubation is determined and taken to the patient's bedside. Anesthetic topical agents and oral liquids if required to facilitate gastric intubation are selected and prepared. An explanation of the procedure, risks benefits and alternatives is performed with patient and sometimes family.

Description of Intra-Service Work: The patient is positioned seated in the upright sniffing position. Anesthetic agents are administered. If appropriate, oral liquids are initiated. The gastric tube is lubricated and passed through the oro, or nasopharynx, into the stomach of an awake, obtunded or sedated patient. Placement of the tube in the stomach is confirmed with auscultation of borborygmi. The tube is then suctioned either manually or by wall suction. An x-ray may be needed at this time to confirm appropriate placement of the tube. The physician reviews the abdominal x-ray for proper gastric tube placement and adjustments of the tube are made as necessary. Manual irrigation of the stomach with irrigant is performed if clinically indicated and manual or wall suction performed. Irrigation and repeat suctioning are performed as many times as clinically appropriate with observation of the tube contents until the condition is determined to be resolved or ruled out.

Description of Post-Service Work: A procedure note is written in the patient's chart. The physician confirms that the gastric tube remains in proper place after any repositioning. An attempt is made to discuss the procedure and outcome with

the patient or any family members that may be available on site. Appropriate follow up care is arranged and the necessary communication with consulting physicians occurs before the encounter ends.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	Jennifer Wiler, MD, FACEP				
Specialty(s):	Emergency Medicine				
CPT Code:	43753				
Sample Size:	67	**Resp N:**	39	**Response:** 58.2 %	
Sample Type:	Panel	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		2.00	**10.00**	15.00	50.00
Survey RVW:	0.45	1.00	**1.30**	1.59	3.00
Pre-Service Evaluation Time:			**3.00**		
Pre-Service Positioning Time:			**3.00**		
Pre-Service Scrub, Dress, Wait Time:			**3.00**		
Intra-Service Time:	2.00	5.00	**10.00**	15.00	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: 1a-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	43753	**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**	**13.00**	**-13.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**3.00**	**6.00**	**-3.00**
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
31575	000	1.10	**RUC Time**

CPT Descriptor Laryngoscopy; flexible fiberoptic; diagnostic

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
29075	000	0.77	**RUC Time**	71,099

CPT Descriptor 1 Application, cast elbow to finger (short arm)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
45330	000	0.96	**CMS Time File**	83,849

CPT Descriptor 2 Sigmoidoscopy, flexible; 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: 16 **% of respondents:** 41.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 43753**	**Key Reference CPT Code:** 31575	**Source of Time** RUC Time
Median Pre-Service Time	6.00	10.00	
Median Intra-Service Time	10.00	10.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0 00	
Median Total Time	**21.00**	**25.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.81	2.88
Urgency of medical decision making	3.94	3.75
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.81	4.06
Physical effort required	2.63	3.25
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.25	3.31
Outcome depends on the skill and judgment of physician	2.88	3.88
Estimated risk of malpractice suit with poor outcome	2.75	3.38

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.50	2.81
Intra-Service intensity/complexity	2.94	3.63
Post-Service intensity/complexity	2.13	2.13

Additional Rationale and Comments

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

The majority of respondents chose 31575, *Laryngoscopy, flexible fiberoptic; diagnostic* as their reference service code. That code has been surveyed by the RUC and appears on the Multispecialty Points of Comparison list. The RUC valuation accepted by Medicare for 31575 is a work RVU of 1.10 with total

time of 28 minutes consisting of 5 minutes pre-service, 5 minutes dress and scrub time., 5 minutes of other per operative time, 8 minutes of intra service, and 5 minutes of post service time.

The 43753 survey respondents had a median work RVU of 1.30 based on a total time of 31 minutes. Because this procedure will typically be reported with an E/M service, we felt some reduction in the pre-service time was appropriate. If we remove the 10 minutes of pre-service evaluation, that drops our total time to 21 minutes. A comparison of that adjusted time to the times and values of reference code 31575 shows it to be about 75 % of the RUC approved time for that code. Appling the same percentage to the RUC surveyed work RVU for that code we get 0.82. We feel like this is a more realistic value for the service in question and make that recommendation to the RUC.

This puts the recommended value between MPC codes 29075, a short arm cast, with 10 minutes of intra service at 0.77 and 45330, a flexible sigmoidoscopy, at 17 minutes of intra service at 0.96 work RVUs. It is also about the same as 11100 biopsy of skin with 12 minutes of intra service time and an RVUw of 0.81. We believe the work in this emergency procedure is slightly higher and offsets the shorter intra-service time for 43753.

SERVICES REPORTED WITH MULTIPLE 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 code

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 91105

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

Specialty Emergency Medicine How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 40472
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Assuming 25% of Medicare patient mix

Specialty Emergency Medicine Frequency 18617 Percentage 46.00 %

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? 10,118 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The breakdown is information from the RUC Medicare database

Specialty EM Frequency 4749 Percentage 46.94 %

Specialty Anes Frequency 1820 Percentage 17.99 %

Specialty GI Frequency 159 Percentage 1.57 %

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? (ie. simila work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 99281

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:43754 Tracking Number M2 Specialty Society Recommended RVU: **0.45**

Global Period: 000 RUC Recommended RVU: **0.45**

CPT Descriptor: Gastric intubation and aspiration, diagnostic; single specimen (eg, acid analysis)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 38 year old female with elevated serum gastrin and suspected achlorhydria is referred for a gastric intubation and aspiration to obtain a specimen for analysis.

Percentage of Survey Respondents who found Vignette to be Typical: 33%

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

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

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

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

Moderate Sedation

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

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

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

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Description of Pre-Service Work:

- Assess for possible contraindications such as swallowing disorder or nasal obstruction
- Review patient history, including prior studies
- Explain procedure and its purpose to the patient
- Answer patient questions
- Verify that all necessary instruments and supplies are readily available
- Supervise patient positioning and prepping

Description of Intra-Service Work:

- The test is performed after an overnight fast
- Informed consent is obtained. Following nasal spray administration of 2% xylocaine, a gastric intubation tube is introduced through one nostril, down the back of the throat, and positioned into the stomach as the patient swallows.
- The tube position is confirmed by auscultation of the abdomen to insure proper placement in the stomach
- A syringe is attached to the tube and the gastric fluid is aspirated. A specimen is collected and evaluated.
- At the conclusion of the procedure, the tube is removed.

Description of Post-Service Work:

- The patient is transferred to the recovery suite. Vital signs are checked post-procedure, and the patient is discharged to home when vital signs are stable.

Treatment recommendations and decisions are made based on the data from the study, including the potential nee for additional medical, pharmacologic, endoscopic, and/or surgical intervention.

- A report including findings and recommendations is dictated and sent to the referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010		
Presenter(s):	Nicholas Nickl, MD; Edward Bentley, MD		
Specialty(s):	ASGE, AGA		
CPT Code:	43754		
Sample Size:	41	**Resp N:** 6	**Response:** 14.6 %
Sample Type:	Panel	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	2.00	50.00
Survey RVW:	0.00	0.22	**0.39**	0.81	1.10
Pre-Service Evaluation Time:			**3.00**		
Pre-Service Positioning Time:			**2.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	1.00	**4.00**	5.00	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 **0.00** 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:	43754	**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:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
91038	000	1.10	**RUC Time**

CPT Descriptor Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
99212	XXX	0.48	**RUC Time**	20,255,798

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92250	XXX	0.44	**RUC Time**	2,126,286

CPT Descriptor 2 Fundus photography with interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
44500	000	0.49	**RUC Time**

CPT Descriptor Introduction of long gastrointestinal tube (eg, Miller-Abbott) (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: 4 **% of respondents:** 66.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 43754**	**Key Reference CPT Code: 91038**	**Source of Time RUC Time**
Median Pre-Service Time	5.00	15.00	
Median Intra-Service Time	10.00	0.00	
Median Immediate Post-service Time	5.00	26.00	
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**	**41.00**
Other time if appropriate		

NTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.75	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.75	2.75
Urgency of medical decision making	2.50	2.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.75	2.50
Physical effort required	2.25	2.25
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.25	2.50
)utcome depends on the skill and judgment of physician	2.75	2.75
Estimated risk of malpractice suit with poor outcome	2.75	2.75

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.75	2.75
Intra-Service intensity/complexity	2.25	2.75
Post-Service intensity/complexity	2.25	2.75

Additional Rationale and Comments

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.*

This procedure is currently reported with code 89130, with a wRVU of 0.45 established by 'CMS/other'. Given the small number of physicians who perform this service, the small response size, the wide variation in responses, and the fact that

the median service performance rate was zero, the specialty societies (AGA, ASGE, ACG) convened a consensus panel consisting of representatives from the respective societies practice management committees. Members of the panel observed the performance of the service at academic institutions (University of Pennsylvania and University of Florida) where the service is performed.

The panel could not identify a compelling reason to change the wRVU of 43754, noting that the service was identical to the existing code 89130. The consensus panel compared the physician work and professional liability of 43754 to representative services performed by a physician. The panel felt that the key reference service, 91038, was not an appropriate comparison in terms of the physician work and that the wRVU of code 91038 was excessive compared to the panel's estimate for code 43754. The panel noted that the median wRVU obtained from the survey, 0.39, undervalued this service compared to the existing wRVU for code 89130. The panel felt that code 44500, introduction of a long gastrointestinal tube, wRVU 0.49, 6/25/5, represented a more appropriate reference comparison in terms of the time, intensity, and physician work of 43754. The panel noted that while code 44500 describes placement of a gastrointestinal tube beyond the stomach, code 43754 included sampling of gastric contents, evaluation of the procedure findings, and generation of management recommendations to the referring physician which would not be captured by any other procedure or E/M service on the date of service, and recommended a comparable RVU based on the additional physician work and intensity of such services. The panel also noted that code 43752, Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report), wRVU 0.81, 5/20/5, was another potential comparator, however code 43754 did not include fluoroscopic guidance and patients typically with difficult esophageal intubations. The panel noted that code 76000, Fluoroscopy (separate procedure), up to 1 hour physician time, had a wRVU of 0.17. Subtracting 0.17 from 0.81 resulted in 0.64, which the consensus panel felt was excessive for the wRVU of 43754. The panel noted that moderate sedation was not inherent to codes 44500, 43752, 91038, 99212 or 89130. Based on the above comparison, the consensus panel recommended a wRVU of 0.45 for code 43754.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each 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) This service is currently reported with code 89130 - Gastric intubation and aspiration, diagnostic, eac specimen, for chemical analyses or cytopathology;

How often do physicians 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? 1000
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 panel discussions and specialty experience.

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? 470
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare frequency as listed in the RUC database for 2008 based on panel discussions and specialty experience.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

)o 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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 89130 - as it was previously reported

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:43755 Tracking Number M3 Specialty Society Recommended RVU: **0.94**
Global Period: 000 RUC Recommended RVU: **0.94**

CPT Descriptor: Gastric intubation and aspiration, diagnostic; with collection of multiple fractional specimens with gastric stimulation, single or double lumen tube (gastric secretory study) (eg, histamine, insulin, pentagastrin, calcium, secretin)

(For gastric acid analysis, use 82930)
(For naso- or oro-gastric tube placement by physician with fluoroscopic guidance, use 43752)
(Report the drug or substance administered. The fluid used to administer the drug(s) is not separately reported.)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48 year old male with persistent dyspepsia partially responsive to pharmacological therapy, diarrhea, and elevated serum gastrin is referred for gastric intubation and collection of multiple specimens for analysis.

Percentage of Survey Respondents who found Vignette to be Typical: 66%

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

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

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work:
- o Assess for possible contraindications such as swallowing disorder or nasal obstruction
- o Review patient history, including prior studies
- o Verify that patient has not taken antisecretory medications
- o Explain procedure and its purpose to the patient
- o Answer patient questions
- o Verify that all necessary instruments and supplies are readily available. Confirm intravenous agent to be used in this procedure.
- o Supervise patient positioning and prepping

Description of Intra-Service Work:
- o Intravenous access is started

o After informed consent is obtained, and following nasal spray administration of 2% xylocaine, a gastric intubation tube is introduced through one nostril, down the back of the throat, and positioned into the stomach as the patient swallows.

o The tube position is confirmed by auscultation of the abdomen to insure proper placement in the stomach

A stimulation agent is administered intravenously by the physician

ɔ A syringe is attached to the drainage tube by the physician

o Timed aspirations are then obtained by the physician, who observes the patient for adverse effects or reactions to the intravenous agent. If there are no reactions, then gastric fluid is aspirated as appropriate by the clinical staff under physician supervision, depending on the nature of the chemical analysis or gastric secretory study performed. The fluid is analyzed.

o At the conclusion of the procedure, the tube is removed.

Description of Post-Service Work:

o Patient is transferred to the recovery suite

o Post procedure vital signs are assessed

o Intravenous access is discontinued. When vital signs are stable, the patient is discharged to home.

o Treatment recommendations and decisions are made based on the data from the study, including the potential need for additional medical, pharmacologic, endoscopic, and/or surgical intervention.

o A report including findings and recommendations is dictated and sent to the referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010		
Presenter(s):	Nicholas Nickl, MD; Edward Bentley, MD		
Specialty(s):	ASGE, AGA		
CPT Code:	43755		
Sample Size:	40	**Resp N:** 6	**Response:** 15.0 %
Sample Type:	Panel	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	4.00	12.00
Survey RVW:	0.93	0.99	**1.10**	1.10	2.50
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**3.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	1.00	**8.00**	48.00	75.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
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:	43755	**Recommended Physician Work RVU: 0.94**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**0.00**	**7.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**25.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 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
91038	000	1.10	**RUC Time**

CPT Descriptor Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
99202	XXX	0.93	**RUC Time**	2,382,775

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
9213	XXX	0.97	**RUC Time**	102,084,135

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
45330	000	0.96	**CMS Time File**

CPT Descriptor Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (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: 3 **% of respondents:** 50.0 **%**

TIME ESTIMATES (Median)	CPT Code: 43755	Key Reference CPT Code: 91038	Source of Time RUC Time
Median Pre-Service Time	7.00	15.00	

Median Intra-Service Time	25.00	0.00
Median Immediate Post-service Time	5.00	26.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	**37.00**	**41.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.67	2.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.67
Urgency of medical decision making	2.67	2.33
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.67	2.33
Physical effort required	2.33	2.33
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.33	2.00
Outcome depends on the skill and judgment of physician	2.33	2.00
Estimated risk of malpractice suit with poor outcome	2.33	2.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.33	1.67
Intra-Service intensity/complexity	2.33	1.67
Post-Service intensity/complexity	2.67	2.67

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an RUP analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
This procedure is currently reported with codes 89130-89141, with the following wRVU established by 'CMS/other': 89130 Gastric intubation and aspiration, diagnostic each specimen, for chemical analyses or cytopathology (baseline-before stimulation) XXX 0.45 wRVU, 89132 Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology; after stimulation, XXX, 0.19 wRVU. 89135, Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); 1 hour, XXX, 0.79 wRVU. 89136, Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); 2 hours, XXX, 0.21 wRVU. 89140, Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); 2 hours including gastric stimulation (eg, histalog, pentagastrin), XXX, 0.94 wRVU. 89141, Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); 3 hours, including gastric stimulation, XXX, 0.85 wRVU. The table below lists currently reported codes and wRVU values.

CPT Code	Long Descriptor	wRVU
89130	Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology;	0.45
89132	Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology; after stimulation	0.19
89135	Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); 1 hour	0.79
89136	Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); 2 hours	0.21
89140	Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); 2 hours including gastric stimulation (eg, histalog, pentagastrin)	0.94
89141	Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); 3 hours, including gastric stimulation	0.85

Given the small number of physicians who perform this service, the small response size, and the wide variation in responses, the specialty societies (AGA, ASGE, ACG) convened a consensus panel consisting of representatives from the respective societies practice management committees. Members of the panel observed the performance of the service at academic institutions (University of Pennsylvania and University of Florida) where the service is performed. The consensus panel compared the physician work and professional liability of 43755 to representative services performed by a physician. The panel felt that the key reference service, 91038, was not an appropriate comparison in terms of the physician work and that the wRVU of code 91038 was excessive compared to the panel's estimate for code 43755. The panel noted that the median wRVU obtained from the survey, 1.10, and the 25th percentile, 0.99, were probably slightly too high compared to the existing wRVU for this procedure. The panel felt that 13 minutes of pre-service time was excessive, and recommended 7 minutes to account for the physician time to ensure that the appropriate intravenous medication was being used for gastric stimulation.

The panel noted that this procedure could be reported using existing codes as 89132+89135, 0.19+0.79 = wRVU 0.98, or as code 89140, wRVU 0.94. The panel noted that code 89140 had 30 minutes of time as established by CMS/other, and felt that code 89140 represented an appropriate comparison in terms of the physician work and PLI. The panel could not identify a compelling reason to change the current valuation of the service. The panel noted that there was additional physician work in code 43755 compared to 43754, as the physician personally administered the intravenous agent, monitored the patient's response to the agent, and performed the initial aspirations of gastric secretions for the first 15 minutes. The panel felt that code 44500, introduction of a long gastrointestinal tube, wRVU 0.49, 6/25/5, represented undervaluation of the physician work compared to the time, intensity, and physician work of 43755. The panel also noted

that code 43752, Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report), wRVU 0.81, 5/20/5, was another potential comparator, however it undervalued the physician work compared to code 43755. Although the service requires fluoroscopic guidance and a technically more difficult tube placement, it does not include administration of the stimulating agent, monitoring the patient's response to that agent, personal performance of the initial aspirations, and medical decision-making about th overall course of the study utilizing the pH analysis of the initial aspiration specimens.. The panel noted that while th intra-service time of 43755 was greater than the MPC comparison codes 99202 and 99213, that there were peaks of intensity during the performance of 43755 associated with the administration of intravenous stimulant, but that overall the intensity of the service was less than the MPC comparison codes. The panel noted that moderate sedation was not inherent to codes 44500, 43752, 91038, 99202, 99213 or 89132-89141. Based on the above comparison, the consensus panel recommended a wRVU of 0.94 for code 43755.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Service is currently reported using code 89140, Gastric intubation, aspiration, and fractional collections (eg, gastric secretory study); 2 hours including gastric stimulation (eg, histalog, pentagastrin)

How often do physicians 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? 200
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 panel discussions and specialty experience.

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 40 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare frequency as listed in the RUC database for 2008 for codes 89132-89141 based on panel discussions and specialty experience.

Specialty	Frequency	Percentage	%
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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. The PLI of code 91038 is 0.12. The PLI of code 89140 is 0.04. For the reasons mentioned above, the consensus panel felt that a PLI of 0.04 was appropriate, as this represented an increase in PLI for 4375X3 compared to 4375X2 given the increased risk with intravenous administration of a stimulation agent.

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:43756 Tracking Number M4 Specialty Society Recommended RVU: **0.77**
Global Period: 000 RUC Recommended RVU: **0.77**

CPT Descriptor: Duodenal intubation and aspiration, diagnostic, includes image guidance; single specimen (eg, bile study for crystals or afferent loop culture)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57 year old female with persistent right upper quadrant abdominal pain, negative abdominal ultrasound, and fluctuating liver enzyme abnormalities is referred for a duodenal intubation and aspiration to obtain a specimen for analysis.

Percentage of Survey Respondents who found Vignette to be Typical: 40.00%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 20%

Is moderate 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:

- Assess for possible contraindications such as swallowing disorder or nasal obstruction
- Review patient history, including prior studies
- Explain procedure and its purpose to the patient
- Answer patient questions
- Verify that all necessary instruments and supplies are readily available
- Supervise patient positioning and prepping

Description of Intra-Service Work:

- The test is performed after an overnight fast
- Intravenous access is started
- After informed consent is obtained, and following nasal spray administration of 2% xylocaine, a duodenal intubation tube is introduced through one nostril, down the back of the throat, and positioned into the stomach as tl patient swallows.
- The tube is positioned under fluoroscopic guidance into the third portion of the duodenum. An IV prokinetic agent is administered if difficulty entering the duodenum is encountered.
- An IV secretogogue is administered

- o A syringe is attached to the tube and the duodenal fluid is aspirated
- o An analysis of the duodenal aspirate is performed
- o At the conclusion of the procedure, the tube is withdrawn

Description of Post-Service Work:

- o The patient is transferred to the recovery suite. Vital signs are checked post-procedure, and the patient is discharged to home when stable. Treatment recommendations and decisions are made based on the data from the study, including the potential need for additional medical, pharmacologic, endoscopic, and/or surgical intervention.
- o A report including findings and recommendations is dictated and sent to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	Nicholas Nickl, MD; Edward Bentley, MD				
Specialty(s):	ASGE, AGA				
CPT Code:	43756				
Sample Size:	41	**Resp N:**	5	**Response:** 12.1 %	
Sample Type:	Panel	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	2.00	4.00
Survey RVW:	0.10	0.80	**1.10**	1.10	2.52
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	10.00	**10.00**	15.00	20.00

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

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: Select Pre-Service Package

CPT Code:	43756	**Recommended Physician Work RVU: 0.77**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
45300	000	0.80	**RUC Time**

CPT Descriptor Proctosigmoidoscopy, rigid; 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
20551	000	0.75	**RUC Time**	201,322

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

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99202	XXX	0.93	**RUC Time**	2,382,775

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature f the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
43752	000	0.81	**RUC Time**

CPT Descriptor Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation 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: 1 **% of respondents:** 20.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 43756**	**Key Reference CPT Code: 45300**	**Source of Time RUC Time**
Median Pre-Service Time	5.00	7.00	
Median Intra-Service Time	15.00	10.00	
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	**25.00**	**27.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.00	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	2.00
Urgency of medical decision making	1.00	1.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	3.00
Physical effort required	3.00	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.00	3.00
Outcome depends on the skill and judgment of physician	2.00	3.00
Estimated risk of malpractice suit with poor outcome	2.00	4.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	1.00	1.00
Intra-Service intensity/complexity	2.00	2.00
Post-Service intensity/complexity	1.00	1.00

Additional Rationale and Comments

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

This procedure is currently reported with code 89100, with a wRVU of 0.60 established by 'CMS/other', and also code 76000, as fluoroscopy is used to position the tube, with a wRVU of 0.17. The sum of these is 0.77 wRVU. Given the small number of physicians who perform this service, the small response size, the fact that the median service performance rate was zero and the wide variation in responses, the specialty societies (AGA, ASGE, ACG) convened a consensus panel consisting of representatives from the respective societies practice management committees. Members of the panel observed the performance of the service at academic institutions (University of Pennsylvania and University of Florida) where the service is performed. The panel noted that only one respondent utilized moderate sedation, and determined that this represented an aberrant situation as the standard of practice was to perform this procedure without the use of moderate sedation.

The panel could not identify a compelling reason for the wRVU of 43756 to change in comparison to the existing code 89100+76000, the sum of which is 0.77. The consensus panel compared the physician work and professional liability of 43756 to representative services performed by a physician. The panel felt that the key reference service, 45300, was an appropriate comparison in terms of the wRVU. The panel noted that the median wRVU obtained from the survey, 1.10, was probably too high, but that the 25th percentile, 0.80, was almost appropriate. The panel noted that code 43752, Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report), wRVU 0.81, 5/20/5, was an appropriate comparator to the physician work and intensity of code 43756. The panel felt that code 44500, introduction of a long gastrointestinal tube, wRVU 0.49, 6/25/5, and 74251 Radiologic examination, small intestine, includes multiple serial films; via enteroclysis tube undervalued this service in terms of the time, intensity, and physician work of 43756. The panel noted that while code 44500 and 74251 describe placement of a gastrointestinal tube, code 43756 included administration of IV secretagogues, sampling and analysis of duodenal contents, evaluation of the procedure findings, and generation of management recommendations to the referring physician which would not be captured by any other procedure or E/M service on the date of service. The panel noted that moderate sedation was not inherent to codes 44500, 43752, 45300, 89100, 76000 or 99212. Based on the above comparison, the consensus panel recommended maintaining a wRVU of 0.77 for code 43756.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your 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 sevice is currently reported using 89100 - Duodenal intubation and aspiration; single specimen (eg, simple bile study or afferent loop culture) plus appropriate test procedure, and 76000, Fluoroscopy (separate procedure), up to 1 hour physician time

How often do physicians 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? 1000
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 panel discussions and specialty experience.

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? 175
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare frequency as listed in the RUC database for 2008 based on panel discussions and specialty experience.

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? (ie. similar work RVU, and specialty) Yes

If no, please select another crosswalk and provide a brief rationale. The PLI of 45300 is 0.04.

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:43757 Tracking Number M5 Specialty Society Recommended RVU: **1.31**
Global Period: 000 RUC Recommended RVU: **1.26**

CPT Descriptor: Duodenal intubation and aspiration, diagnostic, includes image guidance; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube, includes drug administration

For appropriate chemical analysis procedures, see 89049-89240)
(Report the substances(s) or drug(s). The fluid used to administer the drug(s) is not separately reportable)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 51 year old female with persistent unexplained upper quadrant abdominal pain refractory to pharmacological therapy is referred for a duodenal intubation and collection of multiple specimens for analysis.

Percentage of Survey Respondents who found Vignette to be Typical: 50%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 50%

Is moderate 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

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Description of Pre-Service Work:

- Assess for possible contraindications such as swallowing disorder
- Review patient history, including prior studies
- Explain procedure and its purpose to the patient
- Answer patient questions
- Verify that all necessary instruments and supplies are readily available
- Supervise patient positioning and prepping

Description of Intra-Service Work:

- Intravenous access is started

After informed consent is obtained, and following nasal spray administration of 2% xylocaine, a duodenal intubation tube is introduced through one nostril, down the back of the throat, and positioned into the stomach as the patient swallows.

- The tube is positioned under fluoroscopic guidance into the third portion of the duodenum without the aid of intravenous prokinetic agents.

o A timed basal collection of duodenal fluid is obtained
o A stimulation agent is administered intravenously by the physician . A syringe is attached to the drainage tube by the physician.
o A fter a period of 1 minute, duodenal fluid is then aspirated through the drainage tube. Timed aspirations are then obtained by the physician, who observes the patient for adverse effects or reactions to the intravenous stimulation agent. there are no reactions, then duodenal fluid is aspirated at appropriate intervals by the clinical staff under physicia. supervision, depending on the nature of the pancreatic or gallbladder stimulation study performed.
o The critical positioning of the tube is assessed before each collection by back titration and the tube is repositioned as necessary.
o The fluid is analyzed.
o At the conclusion of the procedure, the tube is withdrawn

Description of Post-Service Work:
o Patient is transferred to the recovery suite
o Post procedure vital signs are assessed
o When vital signs are stable, intravenous access is discontinued, and the patient is discharged to home.
o Treatment recommendations and decisions are made based on the data from the study, including the potential need for additional medical, pharmacologic, endoscopic, and/or surgical intervention.
o Report and outcome letter is dictated for the referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	Nicholas Nickl, MD; Edward Bentley, MD				
Specialty(s):	ASGE, AGA				
CPT Code:	43757				
Sample Size:	41	**Resp N:**	4	**Response:** 9.7 %	
Sample Type:	Panel	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	1.00	5.00
Survey RVW:	1.44	1.44	**1.52**	1.86	2.65
Pre-Service Evaluation Time:			**13.00**		
Pre-Service Positioning Time:			**8.00**		
Pre-Service Scrub, Dress, Wait Time:			**3.00**		
Intra-Service Time:	15.00	30.00	**48.00**	64.00	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: Select Pre-Service Package

CPT Code:	43757	**Recommended Physician Work RVU: 1.31**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**0.00**	**7.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**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? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
91022	000	1.44	**RUC Time**

CPT Descriptor Duodenal motility (manometric) study

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
31231	000	1.10	**RUC Time**	330,885

CPT Descriptor 1 Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99242	XXX	1.34	**RUC Time**	1,437,732

CPT Descriptor 2 Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
43752	000	.81	**RUC Time**

CPT Descriptor Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation 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: 2 **% of respondents:** 50.0 %

TIME ESTIMATES (Median)	**CPT Code: 43757**	**Key Reference CPT Code: 91022**	**Source of Time RUC Time**
Median Pre-Service Time	7.00	15.00	
Median Intra-Service Time	40.00	30.00	
Median Immediate Post-service Time	5.00	16.00	
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**	**61.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.50	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	1.50	1.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	4.00
Physical effort required	3.50	3.50
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.00	2.00
Outcome depends on the skill and judgment of physician	2.00	2.00
Estimated risk of malpractice suit with poor outcome	1.50	1.50

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	1.50	2.00
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity	2.00	3.00

Additional Rationale and Comments

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

This procedure is currently reported with code 89105, with a wRVU of 0.50 established by 'CMS/other', and also code 76000, as fluoroscopy is used to position the tube, with a wRVU of 0.17. The sum of these is 0.67 wRVU, which represents an anomaly compared to code 89100 / code 43756, which is placement of a duodenal tube and aspiration of a single specimen. For this reason, the panel felt there was compelling evidence to change the current valuation. Given the small number of physicians who perform this service, the small response size, the fact that the median service performanc rate was zero and the wide variation in responses, the specialty societies (AGA, ASGE, ACG) convened a consensus pane. consisting of representatives from the respective societies practice management committees. Members of the panel observed the performance of the service at academic institutions (University of Pennsylvania and University of Florida) where the service is performed. The panel noted that only one respondent utilized moderate sedation, and determined that this represented an aberrant situation as the standard of practice was to perform this procedure without the use of moderate sedation.

The consensus panel compared the physician work and professional liability of 43757 to representative services performed by a physician. The panel felt that the key reference service, 91022, was too high of an appropriate comparison in terms of the wRVU due to the differences in analyzing the data from the tube studies. The panel felt that the pre-time recommendations of 24 minutes was too high, and recommended a pre-time of 7 minutes, consistent with the recommended pre-time for code 43755. The panel noted that the median wRVU obtained from the survey, 1.52, and the 25th percentile, 1.44, were also too high. The panel noted that code 43752, Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report), wRVU 0.81, 5/20/5, undervalued the physician work and intensity of code 43757. The panel noted that there was additional physician work in code 43757 compared to 43756, as the physician personally administered the intravenous agent, monitored the patient's response to the agent, performed the initial aspirations of duodenal secretions for the first 15 minutes, and was responsible for maintaining the proper position of the tube for the duration of the study. The panel noted that while code 43752 describes placement of a naso- or oro-gastric tube requiring physician skill, code 43757 required placement beyond the stomach and included sampling of duodenal gastric contents, evaluation of the procedure findings, and generation of management recommendations to the referring physician which would not be captured by any other procedure or E/M service on the date of service. The panel noted that moderate sedation was not inherent to codes 43752, 76000, 89100, 89105, 91022 or 99242. Based on the above comparison, the consensus panel recommended a wRVU of 1.31 for code 43757, noting that the magnitude of wRVU difference between their recommendations for 43756 (0.77 to 1.31) justified slightly greater magnitude of wRVU difference between their recommendations for 43754 (gastric tube, single specimen) to 43755 (gastric tube with stimulation and multiple specimens (0.45 to 0.94) due to the added time and complexity of maintaining tube position in 43757.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Service is currently reporting using code 89105 - Duodenal intubation and aspiration; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube, plus 76000, fluoroscopy (separate procedure), up to 1 hour physician time.

How often do physicians 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? 1000
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 panel discussions and specialty experience.

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? 100
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare frequency as listed in the RUC database for 2008 based on panel discussions and specialty experience.

Specialty Frequency Percentage %

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. Code 91022 has a PLI of 0.13, which we believe is excessive. The PLI of code 89100 is 0.03 and the PLI of code 89105 is 0.02. We have recommended a PLI of 0.04 for code 4375X4. For the reasons mentioned above, the consensus panel felt that a PLI of 0.05 for code 4375X5 is appropriate, given the increased risk with intravenous administration of a stimulation agent.

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			43754		43755	
2	February 2010 RUC	CMS	Staff	Gastric intubation and aspiration, diagnostic; single specimen (eg, acid analysis		Gastric intubation and aspiration, diagnostic; with collection of multiple fractional specimens with gastric stimulation, single or double lumen tube (gastric secretory study) (eg, histamine, insulin, pentagastrin, calcium, secretin	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD						
5	TOTAL CLINICAL LABOR TIME			60.0	19.0	77.0	19.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			9.0	19.0	9.0	19.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			48.0	0.0	65.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			3.0	0.0	3.0	0.0
9	PRE-SERVICE						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA	0	3	0	3
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0	5	0	5
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3	5	3	5
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3	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**						
21	Greet Patient and Provide Gowning, Assure Appropriate Medical Records Are Available	L037D	RN/LPN/MTA	3		3	
22	Obtain vital signs	L037D	RN/LPN/MTA	3		3	
23	Provide pre-service education/obtain consent						
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2	
25	Setup scope (non facility setting only)						
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA			2	
27	Sedate/apply anesthesia						
28	**Intra-service**						
29	Performing procedure	L037D	RN/LPN/MTA	25		40	
30	**Post-Service**						
31	Monitor pt following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	5		5	
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3	
33	Clean Scope						
34	Clean Surgical Instrument Package						
35	Complete diagnostic forms and lab requisitions	L037D	RN/LPN/MTA	3		3	
36	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA	2		2	
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	2		2	
38	Discharge day management						
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	RN/LPN/MTA	3		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*						
53	Other Activity (please specify)	L037D	RN/LPN/MTA				
54	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			43754		43755	
2	February 2010 RUC	CMS	Staff	Gastric intubation and aspiration, diagnostic; single specimen (eg, acid analysis		Gastric intubation and aspiration, diagnostic; with collection of multiple fractional specimens with gastric stimulation, single or double lumen tube (gastric secretory study) (eg, histamine, insulin, pentagastrin, calcium, secretin	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility
55	MEDICAL SUPPLIES		Unit				
56	basin, emesis	SJ010	item	1		1	
57	canister, suction	SD009	item	1		1	
58	cap, surgical	SB001	item	2		2	
59	cup, biopsy-specimen sterile 4oz	SL036	item	1		12	
60	cup, drinking	SK018	item	1		1	
61	denture cup	SJ016	item	1		1	
62	drape, non-sterile, sheet 40in x 60in	SB006	item	2		2	
63	gauze, non-sterile 4in x 4in	SG051	item	5			
64	gown, staff, impervious	SB027	item	2		2	
65	iv infusion set	SC018	item			1	
66	kit, iv starter	SA019	kit			1	
67	lidocaine 2% jelly, topical (Xylocaine)	SH048	item	10		10	
68	lubricating jelly (K-Y) (5gm uou)	SJ032	item	4		4	
69	mask, surgical, with face shield	SB034	item	2		2	
70	needle, 19-25g, butterfly	SC030	item			1	
71	pack, minimum multi-specialty visit	SA048	pack	1		1	
72	stop cock, 3-way	SC049	item	1		1	
73	adapter, luer lock	SC065	item	1		1	
74	tape, surgical occlusive 1in (Blenderm)	SG078	item	12		12	
75	tubing, suction, non-latex (6ft uou)	SD132	item	1		1	
76	suction specimen trap	SD121	item	1		1	
77	syringe 50-60ml	SC056	item	1		1	
78	biohazard bag	SM004	item	1		1	
79	biohazard specimen transport bag	SM008	item	1		4	
80	drinking straw	SK020	item	1		1	
81	Film, fluoroscopic 14x17	SK028	item				
82	Label for files-folders	SK043	item	1		1	
83	Equipment						
84	table, exam	EF023	equipment	48.0		65.0	
85	light, exam	EQ168	equipment	48.0		65.0	
86	suction machine (Gomco)	EQ235	equipment	48.0		65.0	
87	Blood pressure monitor	EQ269	equipment	48.0		65.0	
88	Room-Radiographic - Fluroscopic	EL014	equipment				
89	pH conductivity meter	EP030	equipment	48.0		65.0	
90	Table, fluoroscopy	EF024	equipment				
91	Table, for equipment	EF027	equipment	48.0		65.0	

	A	B	C	H	I	J	K
1	AMA/Specialty Society RVS Update Committee Recommendation			43756		43757	
2	February 2010 RUC	CMS	Staff	Duodenal intubation and aspiration, single specimen (eg, bile study for crystals or afferent loop culture)		Duodenal intubation and aspiration, diagnostic; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD						
5	TOTAL CLINICAL LABOR TIME			60.0	19.0	77.0	19.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			9.0	19.0	9.0	19.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			48.0	0.0	65.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			3.0	0.0	3.0	0.0
9	PRE-SERVICE						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA	0	3	0	3
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0	5	0	5
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3	5	3	5
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3	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 Proced**						
21	Greet Patient and Provide Gowning, Assure Appropriate Medical Records Are Available	L037D	RN/LPN/MTA	3		3	
22	Obtain vital signs	L037D	RN/LPN/MTA	3		3	
23	Provide pre-service education/obtain consent						
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2	
25	Setup scope (non facility setting only)						
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA			2	
27	Sedate/apply anesthesia						
28	**Intra-service**						
29	Performing procedure	L037D	RN/LPN/MTA	25		40	
30	**Post-Service**						
31	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	5		5	
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3	
33	Clean Scope						
34	Clean Surgical Instrument Package						
35	Complete diagnostic forms and lab requisitions	L037D	RN/LPN/MTA	3		3	
36	Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA	2		2	
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	2		2	
38	Discharge day management						
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	RN/LPN/MTA	3		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*						
53	Other Activity (please specify)	L037D	RN/LPN/MTA				
54	**End: with last office visit before end of global period**						

	A	B	C	H	I	J	K
1	AMA/Specialty Society RVS Update Committee Recommendation			43756		43757	
2	February 2010 RUC	CMS	Staff	Duodenal intubation and aspiration, single specimen (eg, bile study for crystals or afferent loop culture)		Duodenal intubation and aspiration, diagnostic; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility
55	MEDICAL SUPPLIES:		Unit				
56	basin, emesis	SJ010	item	1		1	
57	canister, suction	SD009	item	1		1	
58	cap, surgical	SB001	item	2		2	
59	cup, biopsy-specimen sterile 4oz	SL036	item	1		9	
60	cup, drinking	SK018	item	1		1	
61	denture cup	SJ016	item	1		1	
62	drape, non-sterile, sheet 40in x 60in	SB006	item	2		2	
63	gauze, non-sterile 4in x 4in	SG051	item				
64	gown, staff, impervious	SB027	item	2			
65	iv infusion set	SC018	item			1	
66	kit, iv starter	SA019	kit			1	
67	lidocaine 2% jelly, topical (Xylocaine)	SH048	item	10		10	
68	lubricating jelly (K-Y) (5gm uou)	SJ032	item	4		4	
69	mask, surgical, with face shield	SB034	item	2		2	
70	needle, 19-25g, butterfly	SC030	item			1	
71	pack, minimum multi-specialty visit	SA048	pack	1		1	
72	stop cock, 3-way	SC049	item	1		1	
73	adapter, luer lock	SC065	item	1		1	
74	tape, surgical occlusive 1in (Blenderm)	SG078	item	12		12	
75	tubing, suction, non-latex (6ft uou)	SD132	item	1		1	
76	suction specimen trap	SD121	item	1		1	
77	syringe 50-60ml	SC056	item	1		1	
78	biohazard bag	SM004	item	1		1	
79	biohazard specimen transport bag	SM008	item	1		3	
80	drinking straw	SK020	item	1		1	
81	Film, fluoroscopic 14x17	SK028	item	1		1	
82	Label for files-folders	SK043	item	1		1	
83	Equipment:						
84	table, exam	EF023	equipment				
85	light, exam	EQ168	equipment	48.0		65.0	
86	suction machine (Gomco)	EQ235	equipment	48.0		65.0	
87	Blood pressure monitor	EQ269	equipment	48.0		65.0	
88	Room-Radiographic - Fluroscopic	EL014	equipment	48.0		65.0	
89	pH conductivity meter	EP030	equipment	48.0		65.0	
90	Table, fluoroscopy	EF024	equipment	48.0		65.0	
91	Table, for equipment	EF027	equipment	48.0		65.0	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2010

Fiducial Marker Placement

The CPT Editorial Panel approved two new add-on codes to report placement of fiducial marker(s) at the time of a primary open or laparoscopic abdominal, pelvic, or retroperitoneal procedure for later stereotactic radiation therapy.

49327 ***Laparoscopy, surgical; with biopsy (single or multiple); with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intra-pelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)***
The RUC reviewed the specialty society's survey results and recommendation for new code 49327. The RUC understood the specialty's difficulty in surveying physicians who perform this service, as it is new technology and will be rarely performed. The RUC agreed with the specialty recommended median survey work RVU of 2.38 and median survey intra-service time of 30 minutes, as compared to the key reference service 49326 *Laparoscopy, surgical; with omentopexy (omental tacking procedure) (List separately in addition to code for primary procedure)* (Work RVU = 3.50, ZZZ global period, 45 minutes of intra-service time). Further, as reported in the survey statistics, the RUC noted that 4932X requires more mental effort and judgment, technical skill and overall is a more intense procedure compared with the reference code. Based on these comparisons, the RUC agreed that 2.38 work RVUs accurately reflects the relative physician work required to perform this service. **The RUC recommends a work RVU of 2.38 for CPT code 49327.**

49412 ***Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intra-pelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)***
The RUC reviewed the specialty society's survey results and recommendation for new code 49412. The RUC understood the specialty's difficulty in surveying physicians who perform this service, as it is new technology and will be rarely performed. The RUC compared the specialty recommended survey 25th percentile work RVU of 1.50 and survey median intra-service time of 20 minutes to the key reference service 44139 *Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)* (Work RVU = 2.23, ZZZ global period, 30 minutes of intra-service time). Further, as reported in the survey statistics, the RUC noted that 49412 requires more mental effort and judgment, technical skill and overall is a more intense service to perform in comparison to the reference code. Additionally, the RUC agreed that code 49412

would require similar intensity and complexity compared with code 55876 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, prostate, single or multiple* (Work RVU = 1.73, 000 day global, 20 minutes of intra-service time). Based on these comparisons, the RUC agreed that 1.50 work RVUs, the survey's 25th percentile, accurately reflects the relative physician work required to perform this service. **The RUC recommends a work RVU of 1.50 for CPT code 49412.**

New Technology: The RUC recommends that CPT codes 49327 and 49412 be placed on the new technology list.

Practice Expense: The RUC recommends no direct practice expense inputs. These services are add-on and will only be performed in a facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
49321		Laparoscopy, surgical; with biopsy (single or multiple)	010	5.44 (No Change)
+● 49327	N1	with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intra-pelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure) (Use 49327 in conjunction with laparoscopic abdominal, pelvic, or retroperitoneal procedure[s] performed concurrently) (For placement of interstitial device[s] for intra-abdominal, intrapelvic, and/or retroperitoneal radiation therapy guidance concurrent with open procedure, use 49412) (For percutaneous placement of interstitial device[s] for intra-abdominal, intrapelvic, and/or retroperitoneal radiation therapy	ZZZ	2.38

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		guidance, use 49411)		
Introduction, Revision, Removal				
+● 49412	N2	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intra-pelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure) (Use 49412 in conjunction with open abdominal, pelvic, or retroperitoneal procedure[s] performed concurrently) (For placement of interstitial device[s] for intra-abdominal, intrapelvic, and/or retroperitoneal radiation therapy guidance concurrent with laparoscopic procedure, use 49327) (For percutaneous placement of interstitial device(s) for intra-abdominal, intra-pelvic, and/or retroperitoneal radiation therapy guidance, use 49411)	ZZZ	1.50
Male Genital System **Prostate** **Other Procedures**				
▲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)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49327 Tracking Number N1 Specialty Society Recommended RVU: **2.38**
Global Period: ZZZ RUC Recommended RVU: **2.38**

CPT Descriptor: Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intra-pelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57-year old male with suspected single hepatocellular carcinoma in the right hepatic lobe is found at the time of planned laparoscopic resection to have a second lesion not amenable to resection. After the primary lesion is resected, tracking fiducial implants are placed for later stereotactic radiation treatment. [Note that 49327 is an add-on code. When completing this survey, only consider the additional physician work related to 49327.]

Percentage of Survey Respondents who found Vignette to be Typical: 83%

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

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

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work: None

Description of Intra-Service Work: The planned primary laparoscopic procedure is performed as indicated (reported separately). If complete tumor excision is accomplished, fiducials may be placed to enable adjuvant radiotherapy. If tumor is debulked or biopsied fiducials are placed to delineate residual disease for post-operative radiation therapy as indicated. A preloaded delivery system is loaded with 3-5 mm soft tissue fiducials is then positioned into and around the tumor using palpation, visualization or image guidance if indicated. Multiple deployments may be required to position 2-6 fiducials. This is repeated as necessary until all fiducials are placed. Additional image guidance may be utilized to verify the position of the fiducials as well as to evaluate for any immediate complication.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS				
Specialty(s):	general surgery				
CPT Code:	49327				
Sample Size:	200	**Resp N:**	12	**Response:** 6.0 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	2.00	30.00
Survey RVW:	1.50	1.94	**2.38**	2.63	3.50
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	15.00	**30.00**	30.00	45.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
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: ZZZ Global Code

CPT Code:	49327	**Recommended Physician Work RVU: 2.38**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**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**
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? 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
49326	ZZZ	3.50	**RUC Time**

CPT Descriptor Laparoscopy, surgical; with omentopexy (omental tacking procedure) (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
		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
49411	000	3.82	**RUC Time**

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

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 66.6 %

TIME ESTIMATES (Median)	**CPT Code: 49327**	**Key Reference CPT Code: 49326**	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	45.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**30.00**	**45.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.25	2.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	2.75
Urgency of medical decision making	2.88	2.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.75	3.50
Physical effort required	3.13	3.13
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	3.50	3.38
Estimated risk of malpractice suit with poor outcome	3.13	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.63	2.38
Intra-Service intensity/complexity	3.38	3.13
Post-Service intensity/complexity	2.13	2.00

Additional Rationale and Comments

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

Stereotactic radiosurgery (SRS) is performed throughout the entire body. In February 2009, the CPT Editorial Panel approved new codes to report fiducial placement in the thorax and abdomen. The new codes for bronchoscopic and percutaneous placement of fiducial markers were assigned a 000-global period and surveyed and reviewed by the RUC at the April 2009 meeting.

The codes for the open and laparoscopic approach were assigned a 10-day global period, which the ACS determined would not be appropriate as a surgeon would never performed a laparotomy or laparoscopy solely to place fiducials. At the October 2009 CPT meeting, the Panel accepted an appeal to revise the codes as add-ons to open or laparoscopic intra-abdominal, intra-pelvic, and/or retroperitoneal primary procedures.

The American College of Surgeons conducted a RUC survey for the February 2010 meeting, but only collected nine surveys, two of which had a financial conflict of interest. We requested additional time to collect more surveys. As shown in the summary data table, we now have responses from 12 (non-conflicted) surgeons. A general surgeon, who is a member of the CyberKnife Society indicated that he believes the financial disclosure question precludes a majority of the limited number of general surgeons familiar with the practice of radiosurgery from responding to the survey.

To assist with developing a recommendation for the new codes, the College convened an expert panel representing general surgeons and surgeons who practice surgical oncology who do not have a financial conflict The panel reviewed the survey data for 49327 and agree that the median intra-time of 30 minutes accurately reflects the time for laparoscopic placement of fiducials. The panel agrees that this time compares well with the intra-time of 45 minutes for the key reference code 49326 and also compares well with the intra-time of 40-45 minutes for the bronchoscopic fiducial placement code (31626) and percutaneous fiducial placement codes (32553 and 49411). We recommend the survey median RVW of 2.38, which results in an IWPUT of 0.079. This intensity is similar to the other current fiducial placement codes (31626=0.074; 32553=0.064; 49411=0.072).

To support this recommendation, we reviewed a list of all MPC codes with a ZZZ-global period and found only one code with 30 minutes of intra-time (13133 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less)*. Code 13133 has an RVW of 2.19 and IWPUT of 0.073 and is typically performed in an office setting. We believe the recommended RVW of 2.38 for 49327 with an intensity of 0.079 conservatively reflects the greater intensity and complexity of treating a patient undergoing a major open tumor resection, facing subsequent stereotactic radiosurgery, compared with an office or outpatient procedure for complex repair of a laceration.

SERVICES REPORTED WITH MULTIPLE 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. 49327 can be added to any LAPAROSCOPIC, intra-abdominal, intra-pelvic, and/or retroperitoneal primary procedure to place fiducial implants for later stereotactic radiation treatment .

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49329 Unlisted laparoscopy procedure, abdomen, peritoneum and omentum

Alternatively, any major intra-abnominal laparoscopic procedure for tumor resection may have been reported with a modifier -22 to account for the additional work to mark unresectable tumors for later sterotactic radiation treatment

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

Specialty general 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. Unable to estimate national frequency

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 250
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The frequency is unknown since unlisted codes for the entire abdomen are the only way to code 49412. Surgical oncologists performing major intra-abdominal tumor resections that might require placement of fiducials on average perform 2 to 3 per month - this would be for both Medicare and non-Medicare aged patients.

pecialty general surgery Frequency 250 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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 49435

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:49412 Tracking Number N2 Specialty Society Recommended RVU: **1.50**
Global Period: ZZZ RUC Recommended RVU: **1.50**

CPT Descriptor: Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intra-pelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old female is found at the time of laparotomy to have an unresectable pancreatic adenocarcinoma in the head of the pancreas. Tracking fiducial implants are placed for later stereotactic radiation treatment. [Note that 49412 is an add-on code. When completing this survey, only consider the additional physician work related to 49412.]

Percentage of Survey Respondents who found Vignette to be Typical: 67%

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

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

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work: None

Description of Intra-Service Work: The planned primary procedure via laparotomy is performed as indicated (reported separately). If complete tumor excision is accomplished, fiducials may be placed to enable adjuvant radiotherapy. If tumor is debulked or biopsied fiducials are placed to delineate residual disease for post-operative radiation therapy as indicated. A preloaded delivery system is loaded with 3-5 mm soft tissue fiducials is then positioned into and around the tumor using palpation, visualization or image guidance if indicated. Multiple deployments may be required to position 2-6 fiducials. This is repeated as necessary until all fiducials are placed. Additional image guidance may be utilized to verify the position of the fiducials as well as to evaluate for any immediate complication.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS				
Specialty(s):	general surgery				
CPT Code:	49412				
Sample Size:	200	**Resp N:**	12	**Response:** 6.0 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**4.00**	40.00	210
Survey RVW:	1.00	1.50	**2.00**	2.63	3.50
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	15.00	**20.00**	30.00	30.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
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: ZZZ Global Code

CPT Code:	49412	**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:		**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**
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? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
44139	ZZZ	2.23	**RUC Time**

CPT Descriptor Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)

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

MPC CPT Code 1	Global	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
49411	000	3.82	**RUC Time**

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

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 50.0 **%**

TIME ESTIMATES (Median)	CPT Code: 49412	Key Reference CPT Code: 44139	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)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.67	2.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.00
Urgency of medical decision making	3.33	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.33	3.00
Physical effort required	2.67	2.83
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.17	3.17
Outcome depends on the skill and judgment of physician	3.67	3.67
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	2.67	2.33
Intra-Service intensity/complexity	3.00	2.67
Post-Service intensity/complexity	1.83	1.67

Additional Rationale and Comments

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

Stereotactic radiosurgery (SRS) is performed throughout the entire body. In February 2009, the CPT Editorial Panel approved new codes to report fiducial placement in the thorax and abdomen. The new codes for bronchoscopic and percutaneous placement of fiducial markers were assigned a 000-global period and surveyed and reviewed by the RUC at the April 2009 meeting.

The codes for the open and laparoscopic approach were assigned a 10-day global period, which the ACS determined would not be appropriate as a surgeon would never performed a laparotomy or laparoscopy solely to place fiducials. At the October 2009 CPT meeting, the Panel accepted an appeal to revise the codes to be add-on codes for open or laparoscopic intra-abdominal, intra-pelvic, and/or retroperitoneal primary procedures.

The American College of Surgeons conducted a RUC survey for the February 2010 meeting, but only collected nine surveys, two of which had a financial conflict of interest. We requested additional time to collect more surveys. As shown in the summary data table, we now have responses from 12 (non-conflicted) surgeons. A general surgeon, who is a member of the CyberKnife Society indicated that he believes the financial disclosure question precludes a majority of the limited number of general surgeons familiar with the practice of radiosurgery from responding to the survey.

To assist with developing a recommendation for the new codes, the College convened an expert panel representing general surgeons and surgeons who practice surgical oncology who do not have a financial conflict The panel reviewed the survey data for 49412 and agree that the median intra-time of 20 minutes accurately reflects the time for placement of fiducials during an open procedure. The panel agrees that this time compares well with the intra-time of 30 minutes for the key reference code 44139 and also compares well with the intra-time of 40-45 minutes for the bronchoscopic fiducial placement code (31626) and percutaneous fiducial placement codes (32553 and 49411). We recommend the survey 25th percentile RVW of 1.50, which results in an IWPUT of 0.075. This intensity is similar to the other current fiducial placement codes that have been reviewed by the RUC (31626=0.074; 32553=0.064; 49411=0.072).

To support this recommendation, we reviewed a list of all MPC codes with a ZZZ-global period and found no codes with 20 minutes of intra-time. The ZZZ MPC code with the lowest intra-time (23 minutes) is 13122 *Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)*. Code 13122 has an RVW of 1.44 and IWPUT of 0.063. We believe the recommended RVW of 1.50 for 49412 with an intensity of 0.075 conservatively reflects the greater intensity and complexity of treating a patient undergoing a major open tumor resection, facing subsequent stereotactic radiosurgery, compared with an office or outpatient procedure for complex repair of a laceration.

SERVICES REPORTED WITH MULTIPLE 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. 49412 can be added to any OPEN, intra-abdominal, intra-pelvic, and/or retroperitoneal primary procedure to place fiducial implants for later stereotactic radiation treatment .

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49999 Unlisted procedure, abdomen, peritoneum and omentum
Alternatively, any major intra-abnominal open procedure for tumor resection may have been reported with a modifier -22 to account for the additional work to mark unresectable tumors for later sterotactic radiation treatment

How often do physicians 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? 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. Unable to estimate national frequency

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 250
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The frequency is unknown since unlisted codes for the entire abdomen are the only way to code 49412. Surgical oncologists performing major intra-abdominal tumor resections that might require placement f fiducials on average perform 2 to 3 per month - this would be for both Medicare and non-Medicare aged patients.

Specialty general surgery Frequency 250 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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 15171

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
Direct Inputs

CPT Long Descriptor:

49412 Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intra-pelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)

49327 Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intra-pelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)

FACILITY ONLY

NO CLINICAL STAFF, SUPPLIES, OR EQUIPMENT RECOMMENDED FOR EITHER SETTING

AMA/Specialty Society RVS Update RUC
Summary of Recommendations

April 2010

Transurethral Radiofrequency Bladder Neck and Urethra

In February 2010, the CPT Editorial Panel converted a Category III code to a Category I code to describe minimally invasive treatment for individuals with stress urinary incontinence due to hypermobility who have failed conservative non-surgical alternatives and/or who are not viable candidates for surgery.

53860 ***Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence***

The RUC reviewed code 53860 and compared it to three similar services 57522 *Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision* (work RVU = 3.67 and 20 minutes intra-service time), 17106 *Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm* (work RVU = 3.69 and 30 minutes intra-service time), and 64626 *Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level* (work RVU = 3.92 and 30 minutes intra-service time). The RUC determined the surveyed intra-service time of 30 minutes and a work RVU of 3.97 for code 53860 appropriately accounts for the work required to perform this service and appropriately places this service in the proper rank order relative to similar services. **The RUC recommends a work RVU of 3.97 for 53860.**

For further support, the RUC compared 53860 to MPC code 64721 *Neuroplasty and/or transposition; median nerve at carpal tunnel* (work RVU = 4.97 and 25 minutes intra-service time) and determined 53860 required similar intensity and complexity to perform as 64721. However, code 64721 includes a half discharge day and one more 99213 office visit than 53860. The RUC removed the associated half discharge day and hospital visit and then added 0.12 RVUs associated with the additional 5 minutes of intra-service time for 53860 (30 minutes intra-service time) to arrive at a work RVU of 3.97.

64721	4.97
- half 99238	-0.64
- 99212	-0.48
	3.85
+ 5 minutes x (0.0239 IWPUT) =	+ 0.12
Recommended work RVU for 53860	**3.97**

The specialty society indicated and the RUC agreed that two 99213 offices visits are required for this service as the patient needs to be seen once in the first two weeks to assess any complications and again 2 weeks to 1 month later to evaluate the efficacy of the treatment.

New Technology
The RUC recommends that 53860 be placed on the new technology/new service list.

292

Practice Expense
The RUC reviewed the direct inputs for 53860 and recommends the modified clinical labor time, medical supplies and equipment.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
• 53860	DD1	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	090	3.97
D 0193T		~~Transurethral, radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence~~ (0193T has been deleted. To report, use 53860)		N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:53860 Tracking Number DD1 Specialty Society Recommended RVU: **4.24**

Global Period: 090 RUC Recommended RVU: **3.97**

CPT Descriptor: TRANSURETHRAL RADIOFREQUENCY MICRO-REMODELING OF THE FEMALE BLADDER NECK AND PROXIMAL URETHRA FOR STRESS URINARY INCONTINENCE

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old obese (BMI 35) woman G2P3 with Type II diabetes and a five year history of stress urinary incontinence of 4-5 episodes a day requiring pad changes not sufficiently treated with biofeedback and pelvic floor strengthening despite more than 18 months of therapy. Her incontinence is bothersome when she coughs or sneezes or picks up heavy items, resulting in leakage. She also leaks significantly during exercise which has limited her ability to lose weight, thus negatively impacting her diabetes as well. She is not a good candidate for surgical treatment due to her obesity and her diabetes. The doctor discussed bulking agents but explained that there was no data on her type of incontinence and that it could take several injections to get the desired effect.

Percentage of Survey Respondents who found Vignette to be Typical: 76%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 7% , In the ASC 6%, In the office 87%

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

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

Moderate Sedation

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

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: Includes services proved from the day before surgery until the time of the procedure and may include: (1) obtaining and reviewing laboratory studies and urologic x-rays before the procedure; (2) reviewing office notes and treatment plan; (3) communicating with other health care professionals, e.g., family physician, anesthesiologist; (4) communicating with the patient to explain operative risks and benefits and to obtain informed consent; (5) dressing for surgery, waiting for anesthesia (e.g., administering general, spinal, epidural or local anesthesia or monitored anesthesia care with IV sedation), positioning, prepping and draping the patient and scrubbing; (6) preparing and checking needed equipment for surgery and any other non "skin-to-skin" work in the operating room. Does not include: evaluation and management service, at which time the decision to provide the procedure was made.

Description of Intra-Service Work: The patient undergoes an outpatient or in-office minimally invasive transurethral radiofrequency treatment to increase the compliance of the bladder neck and proximal urethra for SUI under local anesthesia. The procedure is performed by the urologist/ urogynecologist under a peri-urethral local anesthetic block and

lidocaine slurry in the bladder. The patient is placed in the dorsal lithotomy position, the angle of the urethra is determined by inserting a q-tip into the urethra and the local anesthetic (5cc of 1 or 2% lidocaine) is injected in 2 positions at 3 and 9 o'clock at the periurethral sulchus. Once the local anesthesia has taken effect, the bladder is drained with a catheter, the bladder is initially filled with 30cc of sterile water, the device is placed transurethrally without image guidance and the balloon inflated. The proper position of the device is determined prior to treatment through palpation of the balloon at th bladder neck and verifying on visual markings at the urethral meatus the length of the urethra prior to treatment. Nine treatment cycles are performed to complete the overall treatment during this single office visit. The probe is repositioned throughout the treatment, resulting in remodeled areas at varying positions at the bladder neck and proximal urethra. The probe is then removed and the patient voids prior to discharge.

Description of Post-Service Work: Includes the following: (1) all post-operative are on the day of the procedure, including patient stabilization, post-operative orders, communicating with the family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the operating or procedure room; (2) monitoring the patient in the out-patient department or office procedure room to be sure the patient can urinate before going home, instructing the patient in intermittent self-catheterization, if necessary, and admitting the patient to the hospital, if necessary; (3) all post-operative hospital visits and discharge-day management; (4) all post-discharge office visits for this procedure for 90 days after the day of the procedure are considered part of the post-operative work for this procedure (including evaluation of periodic laboratory reports and medication adjustment).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	James Giblin, MD, Richard Gilbert, MD, George Hill, MD, Lora Plaskon, MD				
Specialty(s):	Urology, Gynecology				
CPT Code:	53860				
Sample Size:	1437	**Resp N:**	26	**Response:** 1.8 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.25	**7.50**	11.50	45.00
Survey RVW:	3.00	7.55	**10.83**	11.50	20.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	9.00	25.00	**30.00**	32.50	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):	**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: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	53860	**Recommended Physician Work RVU: 4.24**		
		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:	**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):	**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
53852	090	10.83	**RUC Time**

CPT Descriptor Transurethral destruction of prostate tissue; by radiofrequency thermotherapy

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
29893	090	6.32	**RUC Time**	1,596

CPT Descriptor 1 Endoscopic plantar fasciotomy

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64721	090	4.97	**RUC Time**	105,647

CPT Descriptor 2 Neuroplasty and/or transposition; median nerve at carpal tunnel

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:** 25.0 %

TIME ESTIMATES (Median)	**CPT Code: 53860**	**Key Reference CPT Code:** 53852	**Source of Time RUC Time**
Median Pre-Service Time	7.00	60.00	
Median Intra-Service Time	30.00	58.00	
Median Immediate Post-service Time	15.00	45.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	46.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**98.00**	**232.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.73	3.46
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.92	3.38
Urgency of medical decision making	2.69	2.85
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.42	3.46
Physical effort required	2.92	3.04
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.85	3.08
Outcome depends on the skill and judgment of physician	3.58	3.38
Estimated risk of malpractice suit with poor outcome	2.81	2.92

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.35	3.54
Intra-Service intensity/complexity	3.27	3.27
Post-Service intensity/complexity	3.15	2.77

Additional Rationale and Comments

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

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0193T

How often do physicians 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 Gynecology How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 451
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 information provided by the manufacturer.

Specialty Urology Frequency 226 Percentage 50.11 %

Specialty Gynecology Frequency 225 Percentage 49.88 %

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? 101
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 information provided by the manufacturer.

Specialty Urology Frequency 50 Percentage 49.50 %

Specialty Gynecology Frequency 51 Percentage 50.49 %

Specialty Frequency 0 Percentage 0.00 %

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

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'rofessional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 57522

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

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

CPT Long Descriptor: TRANSURETHRAL RADIOFREQUENCY MICRO-REMODELING OF THE FEMALE BLADDER NECK AND PROXIMAL URETHRA FOR STRESS URINARY INCONTINENCE

Global Period: 090

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

The recommendations were developed by a Panel consisting of six physicians who represents urologic and gynecologic 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 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

Prepare and position patient/ monitor patient

Intra-Service Clinical Labor Activities:

Assist physician during procedure by monitoring patient

Handing instruments to the physician during procedure

Assist physician during procedure

Post-Service Clinical Labor Activities:

Provide follow up information to patient

	A	B	C	D	E
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**53860**	
2	**Meeting Date: April 2010**	**CMS**	**Staff**	**TRANSURETHRAL RADIOFREQUENCY MICRO-REMODELING OF THE FEMALE BLADDER NECK AND PROXIMAL URETHRA FOR STRESS URINARY INCONTINENCE**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**90**	**90**
5	**TOTAL CLINICAL LABOR TIME**		L037D	**158.0**	**60.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**		L037D	**35.0**	**60.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**		L037D	**51.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**		L037D	**72.0**	**0.0**
9	**PRE-SERVICE**				
10	**Start: Following visit when decision for surgery or procedure made**				
11	Complete pre-service diagnostic & referral forms		L037D	**5**	**5**
12	Coordinate pre-surgery services		L037D	**10**	**20**
13	Schedule space and equipment in facility		L037D	**0**	**8**
14	Provide pre-service education/obtain consent		L037D	**10**	**20**
15	Follow-up phone calls & prescriptions		L037D	**10**	**7**
16	Other Clinical Activity (please specify)		L037D		
17	**End: When patient enters office/facility for surgery/procedure**				
18	**SERVICE PERIOD**				
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**				
20	Greet patient, provide gowning, ensure appropriate medical records are available		L037D	**3**	
21	Obtain vital signs		L037D	**3**	
22	Prepare room, equipment, supplies		L037D	**2**	
23	Setup scope (non facility setting only)		L037D	**2**	
24	Prepare and position patient/ monitor patient/ set up IV		L037D	**2**	
25	Sedate/apply anesthesia				
26	**Intra-service**				
27	Assist physician in performing procedure		L037D	**30**	
28	**Post-Service**				
29	Clean room/equipment by physician staff		L037D	**3**	
30	Clean Surgical Instrument Package				
31	Discharge day management		L037D	**6**	
32					
33	**POST-SERVICE Period**				
34	**Start: Patient leaves office/facility**				
35	Conduct phone calls/call in prescriptions				
36	*Office visits:*				
37	*List Number and Level of Office Visits*				
38	99211 16 minutes		16		
39	99212 27 minutes		27		
40	99213 36 minutes		36	**2**	
41	99214 53 minutes		53		
42	99215 63 minutes		63		
43	Other				
44	*Total Office Visit Time*			**72**	**0**
45	Other Activity (please specify)				
46	**End: with last office visit before end of global period**				

	A	B	C	D	E
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**53860**	
2	**Meeting Date: April 2010**	**CMS**	**Staff**	**TRANSURETHRAL RADIOFREQUENCY MICRO-REMODELING OF THE FEMALE BLADDER NECK AND PROXIMAL URETHRA FOR STRESS URINARY INCONTINENCE**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
47	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**		
48	Pack, minimum multi-specialty visit	SA048		3	
49	drape-towel, sterile 18in x 26 in	SB019		3	
50	IV tubing	SC019		6	
51	water, sterile for irrigation (250-1000 ml uou)	SH074		1	
52	cup-tainer, sterile, graduated 1000 ml	SL038		1	
53	lidocaine 4% soln, topical (Xylocaine)	SH050		1	
54	lidocaine 1%-2% inj (Xylocaine)	SH047		10	
55	swab, proto, 16in	SJ052		1	
56	10cc syringe	SC051		1	
57	30cc syringe	SC054		1	
58	underpad 2 ft x 3ft (Chux)	SB044		3	
59	urinary catheter	SD024		1	
60	povidone soln (betadine)	SJ041		60	
61	applicator, spong-tipped	SG009		2	
62	face shield	SB034		2	
63	Needle 18-27 gauge	Sc029		2	
64	Sodium chloride 0.9 irrigation (500-1000 ml uou)	SH069		1	
65	surgical cap	SB001		2	
66	gown, surgical, sterile	SB028		2	
67	drape, sterile, femoral	Sb009		1	
68	cup, sterile, 8 oz	SL157		1	
69	swab-pad, alcohol	SJ053		2	
70	gloves, sterile	SB024		2	
71	lubricating jelly (KY) 5gm uou) jelly	SJ032		4	
72	sterile drape for mayo stand	SB020		1	
73	Renessa Probe	See Invoice		1	
74	feminine pad maxi	SK051		1	
75	towel, nono-sterile	SB042		3	
76	Disenfectant spray	SM012		1	
77	shoe covers	SB039		2	
78	**Equipment**	**CMS Code**			
79	exam table	EF023		**123.0**	
80	light	EQ168		**123**	
81	mayo stand	EF015		**51**	
82	Renessa Generator	See Invoice		**51**	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2010

Posterior Tibial Nerve Stimulation

In February 2010, the CPT Editorial Panel created a new code to report posterior tibial neurostimulation as a treatment for urinary incontinence.

64566
The RUC reviewed the survey results from 39 gynecologists and urologists for 64566. The specialty society indicated and the RUC agreed that the survey respondents overestimated the total time and work required for this service. The specialty society indicated that the placement of the needle by the physician takes 5 minutes and this service is typically performed once a week, for 12 weekly treatments. The RUC agreed with the following modified physician time for each encounter of: 5 minutes pre-service, 5 minutes intra-service and 5 minutes post-service time. The RUC compared 64566 to 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66 and 5 minutes pre, 5 minutes intra and 3.5 minutes post-time) and 64455 *Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, MortonÆs neuroma)* (work RVU = 0.75 and 10 minutes pre, 5 minutes intra and 5 minutes post-time) and determined that the physician work, time and complexity required to perform these services is similar. With these references the RUC determined that the specialty society building block recommended work RVU of 0.60 was supported. The IWPUT for 64566 if 0.0662 is less than that for reference codes 20552 (0.0939) and 64455 (0.0828). **The RUC recommends a work RVU of 0.60 for code 64566.**

New Technology
The RUC recommends that 64566 be placed on the new technology/new service list.

Practice Expense
The RUC reviewed the direct inputs for 64566 and recommends the modified clinical labor time, medical supplies and equipment.

307

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
64553		Percutaneous implantation of neurostimulator electrodes; cranial nerve (For open placement of cranial nerve (eg, vagal, trigeminal) neurostimulator pulse generator or receiver, see 61885, 61886, as appropriate)	010	2.36 (No Change)
64555		peripheral nerve (excludes sacral nerve) (Do not report 64555 in conjunction with 64566)	010	2.32 (No Change)
●64566	EE1	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming (Do not report 64566 in conjunction with 64555, 95970-95972)	000	0.60

308

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64566 Tracking Number EE1 Specialty Society Recommended RVU: **0.60**

Global Period: 000 RUC Recommended RVU: **0.60**

CPT Descriptor: Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 60-year-old female with 9 yr history of urinary frequency (10 /day), nocturia 2+/night, moderate urgency and 2+ urge incontinence episodes/day who has tried multiple therapies without sustained improvement and is unable to control her urinary symptoms.

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

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

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

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

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

Moderate Sedation

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

Is moderate sedation inherent to this procedure in the office setting? 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; 3) preparing and checking needed equipment for procedure in procedure suite. Does not include: The consultation or evaluation at which time the decision to provide the procedure is made.

Description of Intra-Service Work: The patient is placed in a sitting or supine position and the posterior tibial nerve access site is located. The area is sterilized with an alcohol prep pad and topical lidocaine is applied. The physician opens the sterile needle electrode, holds the needle pointing cephalad, positions the electrode at a 60° angle to the skin and inserts the needle through the skin adjacent to the tibial nerve. After the physician inserts the needle, the lead wire is connected to the stimulator. The adhesive backing from the surface electrode is removed and placed it near the medial aspect of the heel bone on the same leg as the needle electrode insertion. The needle electrode clip is attached by depressing the plunger on the clip to expose the connection hook around the needle electrode and release. The stimulator is turned on by pressing and holding the power button for approximately 2 seconds. An audible tone will sound and symbols will appear on the screen. The test mode is entered by pressing and holding the test button for approximately 2 seconds. The default setting for the test mode is level 0. The current is slowly increased using the adjustment button, while observing the patient's foot for a response. The patient's response is generally a toe flex, or an extension of the entire foot. After observing this, reduce current setting by one level. Based upon patient response and comfort level, the final setting is entered. In case the toe flex

or movement of the foot does not exist. The physician must press the stop button and reposition the needle slightly. Re-enter test mode following the preceding instructions. If repositioning the needle does not lead to a response, discard the needle and repeat the procedure on the other leg. The patient is instructed to rest for 30 minutes while the needle electrode remains in place. The physician leaves the room and is available for any questions by the clinical staff during the 30 minute treatment.

Description of Post-Service Work: 1) Examine patient, check wound and patient progress; 2) Answer patient and family questions; 3) Answer nursing and other staff questions; 4) Write any further necessary orders; 5) Write note in progress note section of medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010					
Presenter(s):	James Giblin, MD, Richard Gilbert, MD, George Hill, MD, Roger Goldberg, MD, Lora Plaskon, MD					
Specialty(s):	Urology, Gynecology					
CPT Code:	64566					
Sample Size:	1237	**Resp N:**	39	**Response:** 3.1 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	10.00	**20.00**	50.00	500.00
Survey RVW:	0.30	1.53	**2.25**	3.67	8.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	5.00	15.00	**30.00**	30.00	70.00

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:	64566	**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:		**5.00**	**7.00**	**-2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**5.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 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
51785	000	1.53	**RUC Time**

CPT Descriptor Needle electromyography studies (EMG) of anal or urethral sphincter, 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
11755	000	1.31	**RUC Time**	25,211

CPT Descriptor 1 Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11721	000	0.54	**RUC Time**	7,382,193

CPT Descriptor 2 Debridement of nail(s) by any method(s); 6 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: 23 **% of respondents:** 39.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 64566**	**Key Reference CPT Code: 51785**	**Source of Time**
Median Pre-Service Time	5.00	10.00	
Median Intra-Service Time	5.00	20.00	
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	**15.00**	**30.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.44	3.21
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.44
Urgency of medical decision making	2.51	2.56
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.15	3.36
Physical effort required	2.59	2.82
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.05	2.26
Outcome depends on the skill and judgment of physician	3.28	3.15
Estimated risk of malpractice suit with poor outcome	2.03	2.18

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.92	2.95
Intra-Service intensity/complexity	3.13	3.18
Post-Service intensity/complexity	2.46	2.54

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 AUA/ACOG/AUGS expert panels reviewed the survey results and recommends using the building block method to recommend a RVU value of 0.60.

Pre-service RVW = 0.0224 x 7 minutes of same day evaluation time equals 0.1568 RVUs

Post-service RVW = 0.0224 x 5 minutes immediate post-service time equals 0.112 RVUs

Intra-service RVW = 0.06624 x 5 minutes of intra-service time) equals 0.3312

Totaling: 0.60 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) 64999

How often do physicians 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? Sometimes

Specialty Gynecology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based upon information provided by the manufacturer.

Specialty Urology Frequency 2750 Percentage 50.00 %

Specialty Gynecology Frequency 2750 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? 1,100
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Educated estimate.

Specialty Urology	Frequency 550	Percentage 50.00 %
Specialty Gynecology	Frequency 550	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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 51736

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

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

CPT Long Descriptor: Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming

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 recommendations were developed by a Panel consisting of six physicians who represents urologic and gynecologic 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 in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Charts are reviewed by clinical staff to verify that PTNS is ordered for patients who meet the criteria.
- Room is prepared and exam table is covered with paper.
- Patients are greeted and a gown is provided.
- Patient education and consent is obtained.
- The nursing staff reviews with patient each step of the treatment and enables patient to ask questions.
- The battery level is checked on the stimulator and appropriate supplies are laid out on the mayo table.

Intra-Service Clinical Labor Activities:

- Clinical staff person hands supplies to the physician during procedure.
- Once the physician establishes the appropriate treatment setting for the patient, the treatment is automatically set for 30 minutes.
- Clinical staff remains with the patient to monitor comfort for a few minutes and then leaves the room.
- The patient is observed after 15 minutes and at the end of treatment.
- When the therapy has been completed, the current becomes inactive and stimulator will sound with a series of 3 beeps.
- Turn off the stimulator by holding down the power button for approximately 2 seconds. Remove the needle electrode clip from the needle electrode. Quickly remove the needle with sterile gloves and a non-sterile 2x2 and place a band-aid over the site. Apply pressure should bleeding occur.
- Disconnect the lead wire from the stimulator and properly dispose of the lead set components.

Post-Service Clinical Labor Activities:

- Clean the room and disinfect stimulator
- Provide follow up information to patient
- Discuss any adverse reaction at insertion site
- Confers with the MD/DO verbally about the session
- Next appt is set up for patient while checking out.

	A	B	C	D	E
1				64566	
2	**Meeting Date: April 2010** **AMA/Specialty Society RVS Update Committee Recommendation**	**CMS**	**Staff**	**Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**000**	**000**
5	**TOTAL CLINICAL LABOR TIME**			**24.0**	**0.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**1.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**20.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**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		
12	Coordinate pre-surgery services				
13	Schedule space and equipment in facility				
14	Provide pre-service education/obtain consent		L037D	**1**	
15	Follow-up phone calls & prescriptions				
16	Other Clinical Activity (please specify)				
17	**End: When patient enters office/facility for surgery/procedure**				
18	**SERVICE PERIOD**				
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**				
20	Greet patient, provide gowning, assure appropriate medical records are available		L037D	**3**	
21	Obtain vital signs		L037D	**3**	
22	Provide pre-service education/obtain consent				
23	Prepare room, equipment, supplies		L037D	**2**	
24	Setup scope (non facility setting only)				
25	Prepare and position patient/ monitor patient/ set up IV		L037D	**2**	
26	Sedate/apply anesthesia		L037D	**2**	
27	**Intra-service**				
28	Assist physician in performing procedure		L037D	**5**	
29	**Post-Service**				
30	Monitor pt. following service/check tubes, monitors, drains				
31	Clean room/equipment by physician staff			**3**	
32	Discharge day management				
33	**End: Patient leaves office**				
34	**POST-SERVICE Period**				
35	**Start: Patient leaves office/facility**				
36	Conduct phone calls/call in prescriptions			**3**	
37	*Office visits:*				
38	*List Number and Level of Office Visits*				
39	99211 16 minutes		16		
40	99212 27 minutes		27		
41	99213 36 minutes		36		
42	99214 53 minutes		53		
43	99215 63 minutes		63		
44	Other				
45	*Total Office Visit Time*			**0**	**0**
46	Other Activity (please specify)				
47	**End: with last office visit before end of global period**				
48	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**		
49	pack, minimum multi-specialty visit	SA048	1		
50	band-aid	SG021	1		
51	gloves, sterile	SB024	2		
52	lidocaine 4% soln, topical (xylocaine)	SH050	10		
53	drape, sterile, for Mayo Stand	SB012	1		
54	drape, towel, sterile 18in x 26in	SB019	2		
55	alcohol swab	SJ053	2		
56	Urgent PC Lead	See Invoice	1		
57	**Equipment**	**CMS Code**			
58	table, power	EF031		**20.0**	
59	light source	EQ167		**20.0**	
60	mayo stand	EF015		**20.0**	
61	Urgent PC Stimulator	See Invoice		**20.0**	

American
Urological
Association

April 7, 2010

Bill Moran, MD
Chair
Practice Expense Subcommittee
Physician Payment Policy and Systems
American Medical Association
515 N. State Street
Chicago, IL 60610'

RE: Tab 13 645XX Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming

Dear Dr. Moran,

The AUA would like to thank you for the opportunity of presenting the practice expense spreadsheet for the above code 645XX. The information submitted for clinical staff time, supplies and equipment passed through the RUC at the recent April meeting in Chicago.

Although the times for clinical staff were approved at 1 minute pre-service, 28 intra-service and 3 minutes post service, the use of the room and equipment to perform this procedure is longer than the times allocated on the PE spreadsheet. The treatment for PTNS takes a total of thirty minutes. This does not include the "services prior to the procedure" and post-service times which totals 13 minutes on the day of the procedure. The room and equipment would not be available to another patient while the PTNS treatment is being performed. Therefore, an additional 15 minutes of equipment time should be allocated to the practice expense of CPT code 645XX.

The AUA wanted to bring forward the additional time the equipment is in use for PTNS so that the appropriate valuation by CMS for equipment time for 645XX can be determined.

Thank you for your consideration.

Sincerely,

James G. Giblin, M.D.
AUA RUC Advisor

Headquarters

Michael T. Sheppard, CPA, CAE
Executive Director

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Linthicum, MD 21090

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AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2009

Salivary Gland Injection for Sialorrhea

The CPT Editorial Panel created code 64611 *Chemodenervation of parotid and submandibular salivary glands, bilateral* to describe the use of an botulinum toxin injection in order to treat sialorrhea. The existing codes available for chemodenervation treatment were considered inappropriate to report for the treatment of sialorrhea as they are not specific to the injection of salivary glands or ducts.

The RUC reviewed survey data from over 30 neurologists who perform this service. While reviewing the survey results, the RUC and specialty concurred that the survey respondents overstated the pre-service scrub, dress, wait and positioning time and recommended no time for these activities. The specialty chose, and the RUC agreed that the standard pre-service package, non-facility procedure without sedation, which includes 7 minutes of pre time. The specialty recommended a pre-service evaluation time of 10 minutes which typically is needed for these patients to find the proper injection point('s), and the RUC concurred. The RUC also agreed with the specialty that the intensity of the five minutes of intra-service time was appropriate considering these patients are quite sick and more difficult to treat than similar botulinum toxin injection services. In addition, the RUC agreed that physician involvement was required post operatively in a follow up office visit and that this service would typically require a level two evaluation and management (99212) in order to assess complications and identify botulinum toxin migration to other muscles in the face.

The RUC agreed with the specialties' rationale for a lower work RVU than the survey median of (2.10 work RVU) after reviewing the following services; 64614 *Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)* (Work RVU = 2.20, 010 global, with pre, intra, and post service time components of 15, 20 and 15 respectively), 11420 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less* (Work RVU = 1.03, 010 day global, with pre, intra, and post service time components of 5, 10 and 5 respectively, including one post-operative office visit), and 56605 *Biopsy of vulva or perineum (separate procedure); one lesion* (Work value = 1.10, 000 global, with pre, intra, and post service time components of 10, 15 and 10 respectively). The RUC concurred that the physician time, intensity, and complexity of code 64611 was more closely aligned with codes 11420 (total time = 36 minutes) and 56605 (total time = 35 minutes) than with its key reference code 64614 (total time = 50 minutes).

The specialties recommended the survey 25th percentile work RVU of 1.00 to provide for proper rank order among other similar services and across specialty services. The RUC agreed with the specialty recommendation after considering the similar services and rank order amongst services. The value has been updated to the 2010 MFS.

The RUC recommends a relative work value of 1.03 for CPT code 64611.

Practice Expense: The RUC reviewed the specialty recommended direct practice expense inputs for new code 64611 and made modifications to the clinical labor time, medical supplies, and equipment for the typical patient scenario.

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.

E/M Increases
Based on the changes made in the 2010 MFS Final Rule, the E/M values have been increased and appropriately incorporated into the overall value of this code.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
•64611	C1	Chemodenervation of parotid and submandibular salivary glands, bilateral (Report 64611 with modifier 52 if fewer than four salivary glands are injected)	010	1.03

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64611 Tracking Number C1 Specialty Society Recommended RVU: **1.03**
Global Period: 010 RUC Recommended RVU: **1.03**

CPT Descriptor: Chemodenervation of parotid and submandibular salivary glands, bilateral

(Report 64611 with modifier 52 if fewer than four salivary glands are injected)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66 year-old man presents with a history of idiopathic Parkinson's disease that has caused progressive disability. He is experiencing choking and drooling is having an impact on his daily living and quality of life as a result of excessive salivary secretion. Oral anticholinergics have failed to achieve adequate control of excessive salivation and the systemic side effects of these medications have been intolerable. Thus, the decision is made to inject the parotid and submandibular salivary glands.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 10% , In the ASC 6%, In the office 84%

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) 33% , Admitted (more than 24 hours) 0%

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

Moderate Sedation

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

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

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

Description of Pre-Service Work: Pre-procedure work includes the work to confirm whether botulinum toxin would be of benefit and identify the appropriate sites, as well as the discussion with the patient of the procedure, its rationale and risks. The physician mixes and dilutes the botulinum toxin.

Description of Intra-Service Work: Intra-service work includes preparation of the region for injections, precise localization of each appropriate gland, and actual botulinum toxin injection at 1-2 sites within the gland. From 2-4 glands are usually injected.

Description of Post-Service Work: Post-service work is the dictated report and other communication with the referring ID. Also, the physician reviews the potential complications and again gives the patient guidelines for calling or returning. Further, the value of repeat injection, the timing of that injection and the long-term prognosis are reviewed. At follow-up visit, physician will will examine patient and discuss treatment success or adverse reactions that may have occurred after the visit. Revise treatment plan(s). Dictate notes for medical chart. Dictate procedure note and a letter to the PCP and/or insurance company.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2009					
Presenter(s):	Kevin Kerber, MD (AANPA); Holly Shill, MD (AANPA); Marianna Spanaki, MD, PhD, MBA (AANPA);Jane Dillon, MD (AAO-HNS); Wayne Koch, MD (AAO-HNS)					
Specialty(s):	American Academy of Neurology Professional Association, American Academy of Otolaryngology - Head and Neck Surgeons					
CPT Code:	64611					
Sample Size:	126	**Resp N:**	31	**Response:** 24.6 %		
Sample Type:	Panel	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	**11.00**	22.50	100.00
Survey RVW:	0.80	1.00	**2.10**	2.20	3.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	1.00	5.00	**5.00**	15.00	45.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
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):	**7.00**	99211x **1.00** 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:	64611	**Recommended Physician Work RVU: 1.03**		
		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:		**5.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**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? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64614	010	2.20	**RUC Time**

CPT Descriptor Chemodenervation of muscule(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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	1.03	**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
56605	000	1.10	**RUC Time**	25,343

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

ther Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 35.4 **%**

TIME ESTIMATES (Median)	**CPT Code: 64611**	**Key Reference CPT Code: 64614**	**Source of Time RUC Time**
Median Pre-Service Time	10.00	15.00	
Median Intra-Service Time	5.00	20.00	
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	16.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**36.00**	**50.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.55	3.18
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.18	3.55
Urgency of medical decision making	2.27	2.36
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.82	3.82
Physical effort required	2.55	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.64	3.00
Outcome depends on the skill and judgment of physician	3.73	3.64
Estimated risk of malpractice suit with poor outcome	3.00	2.55

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.09	3.18
Intra-Service intensity/complexity	3.55	3.73
Post-Service intensity/complexity	2.18	2.45

Additional Rationale and Comments

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

Survey respondents most likely overstated the pre-service time required for this service. AAN and AAO-HNS recommend adjusting the pre-service time to 10 minutes (down from the survey total of 20 minutes). The societies believe a 99212 is the typical follow-up visit rather than a 99211. Code 64614 has 20 minutes intra-service time compared to 5 minutes intra-

service time for the new code. Overall time is also lower. Based on the lower time, we recommend the 25th percentile RVW of 1.00.
The IWPUT for the new code with the recommended times and a 1.00 RVW is 0.0428.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one 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) 64612

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

Specialty Neurology How often? Sometimes

Specialty ENT 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.

Specialty Neurology Frequency 28000 Percentage 80.00 %

Specialty ENT Frequency 7000 Percentage 20.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 8,750
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Neurology Frequency 7000 Percentage 80.00 %

Specialty ENT	Frequency 1750	Percentage 20.00 %
Specialty	Frequency 0	Percentage 0.00 %

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

---

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 64653, similar physician work RVU and performed by neurology and otolaryngology frequently

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, 010, or 090 Day Global Periods
Non Facility Direct Inputs

CPT Long Descriptor: Chemodenervation of parotid and submandibular salivary glands, bilateral

(Report 64611 with modifier 52 if fewer than four salivary glands are injected)

Global Period: 010

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

AANPA and AAO-HNS convened a consensus panel of physicians via conference call and email to review the practice expense inputs.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
The patient's appointment is made/confirmed and pre-procedure instructions are conveyed (ex. hold anticoagulants). Verification of appropriate supplies to administer the toxin are made on an ongoing basis. Toxin is ordered from the pharmacy as needed and stored as appropriate for each brand drug. Appropriate storage of the toxin needs to be maintained, including daily monitoring of the refrigerator temperature and log of the drug stored. The drug is stored locked due to its high cost and abuse potential. On the day of the procedure, patient has vital signs done and the patient is put into a room. Medications are reviewed for contraindications to botulinum toxin. Informational material about the toxin is provided to the patient to review. Consent form is provided to the patients and signed. Patient is instructed to change into gown if necessary. Syringes, needles, alcohol swab are then brought to the procedure room for administration.

Intra-Service Clinical Labor Activities:

Clinical staff is available to help administer the toxin. Assistance may be needed to position the patient on the examination table or, if the procedure is done sitting, hold the head still while the toxin is administered.

Post-Service Clinical Labor Activities:

Patient dresses. Room is cleaned. Patient makes follow-up visit. Staff handles any follow-up phone calls from the patient. Office visit related activities are performed.

	A	B	C	D	E
1	**AMA Specialty Society RVS Update Committee Recommendation**			**64611**	
2	**Meeting Date: 10/2009**	**CMS Code**	**Staff Type**	**Chemodenervation of parotid and submandibular salivary glands, bilateral**	
3	**LOCATION**			**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**10**	**10**
5	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**51.0**	**41.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**3.0**	**8.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**21.0**	**6.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**27.0**	**27.0**
9	PRE-SERVICE				
10	**Start: Following visit when decision for surgery or procedure made**				
11	Complete pre-service diagnostic & referral forms			3	3
12	Coordinate pre-surgery services				
13	Schedule space and equipment in facility				5
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			3	
22	Obtain vital signs			3	
23	Provide pre-service education/obtain consent			3	
24	Prepare room, equipment, supplies			2	
25	Setup scope (non facility setting only)				
26	Prepare and position patient/ monitor patient/ set up IV			2	
27	Sedate/apply anesthesia				
28	**Intra-service**				
29	Assist physician in performing procedure			5	
30	**Post-Service**				
31	Monitor pt. following service/check tubes, monitors, drains				
32	Clean room/equipment by physician staff			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				6
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	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*			**27**	**27**
53	Other Activity (please specify)				
54	**End: with last office visit before end of global period**				

	A	B	C	D	E
1	**AMA Specialty Society RVS Update Committee Recommendation**			**64611**	
2	**Meeting Date: 10/2009**	**CMS Code**	**Staff Type**	**Chemodenervation of parotid and submandibular salivary glands, bilateral**	
3	**LOCATION**			**Non Facility**	**Facility**
55	**MEDICAL SUPPLIES**		**Unit**		
56	phosphate buffered saline solution	SL1007	ml	2	
57	swab-pad, alcohol	SJ053	item	5	
58	gauze, non-sterile 4in x 4in	SG051	item	4	
59	syringe 1ml	SC052	item	4	
60	syringe 5-6ml	SC057	item	1	
61	needle, 18-27g	SC029	item	2	
62	mask, surgical	SB033	item	1	
63	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	4	
64	pack, minimum multi-specialty visit	SA048	pack	2	1
65					
66	**Equipment**				
67	Table, exam	EF023		48.0	27
68	exam light	EQ168		48.0	27

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2010

Amniotic Membrane Placement

In October 2009, the CPT Editorial Panel created two codes, 65778 and 65779, to accurately describe the placement of amniotic membrane for ocular surface wound repair and healing. CMS assigned these codes 090 day global periods and the services were surveyed through the RUC process. Following the survey, the specialty society requested that CMS classify codes as 010 day globals to more accurately describe the physician work and post operative visits described in these services. CMS accepted this request and the recommended values of the two codes are valued accordingly.

65778

The RUC reviewed the survey results for code 65778 *Placement of amniotic membrane on the ocular surface for wound healing; self-retaining* and agreed with the specialty that the survey respondents greatly overestimated the physician work and time components involved in the procedure. This was due to the services incorrectly being surveyed as a 090 day global service. The specialty society chose pre-service time package 5- Procedure without Sedation/Anesthesia Care and removed 7 minutes from the pre-service evaluation, while adding 5 minutes to the pre-service time for positioning and preparation apart from the E/M visit billed on the same day. This results in a pre-service time of 5 minutes for this procedure. The RUC also agreed that the appropriate intra-service time of 5 minutes, immediate post service of 5 minutes and 1 level two office visit (99212) accurately reflects the physician time involved in the service.

The RUC compared the surveyed code to 67820 *Correction of trichiasis; epilation, by forceps only* (Work RVU = 0.71, intra-service = 5 minutes, 000 day global) and 65205 Removal of foreign body, external eye; conjunctival superficial (Work RVU = 0.71, intra-service = 5 minutes, 000 day global). Both these services require similar physician intensity and skill and mental effort to perform, but 65778 has 16 additional minutes of total time due to a level two office visit included in the 010 day global period. Additionally, the RUC noted that adding the work RVUs of 65205 (0.71) and the work RVUs of one 99212 office visit (0.48) comes out to 1.19 total work RVUs. The RUC agreed on a work RVU of 1.19, which accurately reflects relativity amongst the family of services.

The RUC also compared the surveyed code to 67505 *Retrobulbar injection; alcohol* (Work RVU = 1.27, total time = 35 minutes) and 68840 *Probing of lacrimal canaliculi, with or without irrigation* (Work RVU = 1.30, total time = 39 minutes). Both these procedures have slightly more total time and intensity compared to the surveyed code and maintain appropriate relativity amongst physician services. **The RUC recommends 1.19 Work RVUs for 65778.**

65779

The RUC reviewed the survey results for code 65779 *Placement of amniotic membrane on the ocular surface for wound healing; single layer, sutured* and agreed with the specialty that the respondents greatly overestimated the physician work and time components involved in the procedure. This was due to the services incorrectly being surveyed as a 090 day global service. The specialty society chose pre-service time package 1b- Straightforward Patient Procedure (with Sedation/anesthesia) and subtracted 2 minutes from the evaluation time. The following physician service times are recommended: pre-service time = 23 minutes, intra-service time = 16 minutes and immediate post service time = 10 minutes. The RUC agreed with these times as there is no E/M visit billed on the same date of service.

340

To determine the appropriate amount of intra-service time for this service, the RUC reviewed two reference services. 65420 *Excision or transposition of pterygium; without graft* (Work RVU = 4.36, intra-time = 31 minutes) and 65426 *Excision or transposition of pterygium; with graft* (Work RVU = 6.05, intra-service = 47.5 minutes) were reviewed and it was determined that the additional work associated with the placement of the graft in 65426 was 16.5 minutes. The RUC agreed with the specialty that the physician work involved in suturing the single layer on the ocular surface in 65779 and the placing of a graft in the reference service should be 16.5 minutes, as both procedures have similar skill, intensity and physical effort. Having agreed to the intra-service time, the RUC subtracted the work RVUs of the two services to calculate the intensity for this work at 1.69 RVUs. The RUC then added the RVUs for the post operative visits as follows: 0.64 for the half day discharge (99238), 0.97 for the level three office visit (99213) and 0.48 for the level two office visit (99212), for a total of 3.78 work RVUs. Finally, the RUC allowed a small increment for the 33 minutes of same day pre-service and post service time inherent in the procedure, bringing the total to 3.92 work RVUs.

The RUC compared the surveyed code to 65885 *Trabeculoplasty by laser surgery, 1 or more sessions (defined treatment series)* (Work RVU = 3.99 and intra-service time = 15 minutes). The RUC agreed that while the surveyed code has more total time than 65885, 107 minutes and 88 minutes respectively, the intensity and complexity of the reference service is greater and should be valued slightly above 65779. **The RUC recommends 3.92 Work RVUs for 65779.**

Practice Expense
The RUC reviewed these services and direct inputs carefully and made one edit to the equipment for 65778 and agreed with all other inputs recommended by the specialty.

New Technology
The RUC recommends CPT codes 65778 and 65779 be placed on the RUC's new technology listing.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●65778	R1	Placement of amniotic membrane on the ocular surface for wound healing; self-retaining	010	1.19
●65779	R2	single layer, sutured (Do not report 65778, 65779 in conjunction with 65430, 65435, 65780) (For placement of amniotic membrane using tissue glue use 66999)	010	3.92
▲65780		Ocular surface reconstruction; amniotic membrane transplantation, multiple layers (For placement of amniotic membrane without reconstruction using self-retaining or single layer suture technique, see 65778, 65779)	090	10.73 (No Change)

341

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:65778 Tracking Number R1 Specialty Society Recommended RVU: **1.19**

Global Period: 010 RUC Recommended RVU: **1.19**

CPT Descriptor: Placement of amniotic membrane on the ocular surface for wound healing; self-retaining
(Do not report 65778, 65779 in conjunction with 65430, 65435, 65780)
(For placement of amniotic membrane using tissue glue use 66999)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 27-year-old male presented with progressive loss of vision, severe pain and light sensitivity in his right eye immediately after a chemical burn injury. Examination revealed severe ocular inflammation and a large corneal epithelial defect. Topical and systemic medications failed to relieve his symptoms from lack of corneal healing after one week. A self-retaining amniotic membrane device was placed on the corneal surface.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 27% , In the ASC 33%, In the office 38%

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 50%

Is moderate 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: A lid speculum is inserted to the affected eye so that the lid margins and lashes are isolated. Several drops of anesthetics are applied in the fornix.

Description of Intra-Service Work: The amniotic membrane self-retaining device is inserted into the conjunctival fornix and centered over the corneal surface. Topical antibiotics are applied.

Description of Post-Service Work: The patient is seen within 7-10 days for removal of the carrier ring and assessment of corneal wound healing.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010		
Presenter(s):	David Glasser, M.D.		
Specialty(s):	Ophthalmology/corneal fellowship		
CPT Code:	65778		
Sample Size:	175	**Resp N:** 36	**Response:** 20.5 %
Sample Type:	Random	**Additional Sample Information:** Survey was conducted based on an inappropriate global period.	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**4.00**	5.00	50.00
Survey RVW:	1.00	2.26	**4.33**	5.93	11.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	2.00	10.00	**12.50**	40.00	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):	**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: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	65778	**Recommended Physician Work RVU: 1.19**		
		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:		**5.00**	**0.00**	**5.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**5.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**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? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
65426	090	5.93	**RUC Time**

CPT Descriptor Excision or transposition of pterygium; with graft

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
29075	000	0.77	**RUC Time**	71,100

CPT Descriptor 1 Application, cast; elbow to finger (short arm)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11440	010	0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
67820	000	0.71	**RUC Time**

CPT Descriptor Correction of trichiasis; epilation, by forceps only

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

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 27.7 %

TIME ESTIMATES (Median)	CPT Code: 65778	Key Reference CPT Code: 65426	Source of Time RUC Time
Median Pre-Service Time	5.00	20.00	
Median Intra-Service Time	5.00	47.50	
Median Immediate Post-service Time	5.00	12.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	17.50	
Median Office Visit Time	16.0	64.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**31.00**	**161.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.40	2.80
Urgency of medical decision making	3.80	2.80
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.50	3.40
Physical effort required	2.50	3.30
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.60	2.80
Outcome depends on the skill and judgment of physician	3.10	3.40
Estimated risk of malpractice suit with poor outcome	2.80	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	2.50	3.30
Post-Service intensity/complexity	3.10	2.80

Additional Rationale and Comments

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

This code was submitted by industry to describe placement of a self-retaining bandage amniotic membrane appliance to treat a small group of patients with severe corneal surface disease that has failed to respond to more conventional treatment methods. After the code was approved by CPT, it was assigned a 90 day global period by CMS and a survey was performed to determine a physician work value. The survey results were

reviewed by members of the AAO Health Policy Committee (HPC) experienced in RUC methodology and it was apparent that there were issues with the surveys primarily related to the length of the global period.

The membrane component of this device dissolves at about 10 days and the carrier ring is removed. Any additional visits in the remaining 90 day global period are related to treatment of the underlying disease and not to the procedure itself. The number and intensity of the visits would be uncertain and depend primarily on the severity of the disease process itself and totally unrelated to the procedure that was performed. Including visits related to care for the disease process in the global payment for a procedure is inconsistent with our understanding of the intent of the global procedural payment system. CMS allowed the global period to be reduced for CPT 65855 (*trabeculoplasty by laser surgery)]* during the second 5 Year Review because the care provided after the initial recovery from the procedure was related to treatment of the underlying disease. The global for prostate needle biopsy was also reduced by CMS and the RUC using similar logic. We feel that the global for this code should be reduced using the same reasoning

We attempted to communicate with CMS to raise this issue but did not receive a response. We also notified the RUC of the problem and the suggestion was made to come to the RUC with a presentation that was based on a more appropriate global period and allow the RUC to evaluate the presentation and CMS to hear the argument. The HPC convened an expert panel with members familiar with the process and the specific procedure and debated whether the global should be 000 or 10 days. It was felt that a case could be made for both, but that the typical patient would require a single postoperative visit directly related to the procedure at about 7-10 days for the physician to remove the carrier ring. After debate we decided to choose the 10 day global with 1 visit. It was also determined that this procedure would typically be done in conjunction with an EM visit and performed in the office rather than a facility.

The expert panel elected to use a building block method to determine the physician work and add in the established work values for the postoperative visits. Two zero- day global procedures requiring similar physician intensity, skill and mental effort and stress were identified. Zero day globals were chosen for comparison to isolate the physician work component and also to allow a change to 000 global for this code if the RUC and CMS agreed that was more appropriate. Two procedures, 67820 (*epilation for trichiasis*) and 65205 (*removal of conjunctival foreign body*), were chosen. These are both office-based procedures and have been RUC reviewed. They both have a physician WRVU of 0.71. The intraservice times for the procedures are both 5 minutes which the committee also felt was a reasonable estimate of the IST for this procedure. It was estimated that there would be 5 minutes of pre-service time to prepare and position the patient for the procedure, time-out, etc.(not included in the EM visit) and 5 minutes of post time. These times are virtually identical to those for the codes chosen as building blocks.

Therefore the AAO recommends the value of 0.71 for the intra-service work for this procedure. The consensus agreement for postoperative care was for one level 2 visit on day 7-10 for removal of the carrier ring and assessment of healing. The work value for 99212 ***(.48)***] were added to the ISW to produce a **recommended physician WRVU of 1.19** for 65778 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: 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) Billed with an E/M service also

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one 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.	CPT Code	Pre-service	Intra-Service	Post-service	Total Time	Work RVU	Global
4.	99213	3.0	15.00	5.00	23.00	.97	XXX

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 66999

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

Specialty Ophthalmology How often? Sometimes

Specialty How often?

pecialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 8000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

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

Specialty Frequency Percentage %

Specialty Frequency Percentage %

o 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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 65430

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:65779 Tracking Number R2 Specialty Society Recommended RVU: **3.92**

Global Period: 010 RUC Recommended RVU: **3.92**

CPT Descriptor: Placement of amniotic membrane on the ocular surface for wound healing; single layer, sutured
(Do not report 65778, 65779 in conjunction with 65430, 65435, 65780)
(For placement of amniotic membrane using tissue glue use 66999)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old woman presented with decreased vision, photophobia and irritation in her right eye for three weeks. She was originally diagnosed with bacterial keratitis and treated with topical antibiotics. During the current examination, a non-healing corneal epithelial defect was observed without evidence of infection. Frequent lubrication and a bandage contact lens were applied for 5 days with no improvement. An amniotic membrane for healing is applied and sutured in place.

Percentage of Survey Respondents who found Vignette to be Typical: 81.25%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 31% , In the ASC 68.75%, In the office 0%

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 75%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 6.25%

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

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Description of Pre-Service Work: Topical anesthetic is placed in the eye. The eye is prepped and draped in the usual sterile fashion. A plastic adhesive drape is applied and incised. A lid speculum is inserted. The operating microscope is swung into position and adjusted.

Description of Intra-Service Work: Necrotic epithelium is removed with microsponges and forceps. An amniotic membrane graft is trimmed to the appropriate size and peeled from the carrier paper. The smooth basement membrane surface is distinguished from the sticky stromal surface with a microsponge. The membrane is placed in a single layer to over the damaged area so that the basement membrane surface is up. The graft is secured with 8-16 interrupted or running 0-0 nylon sutures. The suture ends are trimmed and the knots are buried. Topical antibiotics are applied. The lid speculum and drapes are removed.

Description of Post-Service Work: The patient is monitored as needed until the membrane dissolves or corneal healing is complete, and the sutures are removed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	David Glasser, M.D.				
Specialty(s):	Ophthalmology/corneal fellowship				
CPT Code:	65779				
Sample Size:	175	**Resp N:**	32	**Response:** 18.2 %	
Sample Type:	Random **Additional Sample Information:** Survey was conducted based on an inappropriate global period.				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	4.00	**5.00**	10.50	50.00
Survey RVW:	4.50	5.92	**6.00**	7.00	10.50
Pre-Service Evaluation Time:			**12.50**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	30.00	**45.00**	46.25	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**131.00**	99211x **0.00** 12x **1.00** 13x **5.00** 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-FAC Straightforw Pat Procedure(w sedate/anes)

CPT Code:	65779	**Recommended Physician Work RVU: 3.92**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**17.00**	**19.00**	**-2.00**
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:		**16.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
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? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
65426	090	5.93	**RUC Time**

CPT Descriptor Excision or transposition of pterygium; with graft

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11444	010	3.16	**RUC Time**	1,485,000

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
65420	000	4.24	**Harvard Time**

CPT Descriptor Excision or transposition of pterygium; without graft

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

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 62.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 65779**	**Key Reference CPT Code: 65426**	**Source of Time RUC Time**
Median Pre-Service Time	23.00	20.00	
Median Intra-Service Time	16.00	47.50	
Median Immediate Post-service Time	10.00	12.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	17.50	
Median Office Visit Time	39.0	64.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**107.00**	**161.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.95	2.95
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	2.85
Urgency of medical decision making	4.10	2.30
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.70	3.60
Physical effort required	3.30	3.35
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.95	3.40
Outcome depends on the skill and judgment of physician	4.00	3.60
Estimated risk of malpractice suit with poor outcome	3.75	3.30

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	3.20
Intra-Service intensity/complexity	3.65	3.45
Post-Service intensity/complexity	3.50	2.95

Additional Rationale and Comments

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

This code was submitted by industry to describe grafting of amniotic membrane to treat patients with severe corneal surface disease that have failed to respond to more conventional treatment methods. This procedure is not as extensive as the previously RUC approved ocular surface reconstruction codes and it was felt that a new code was needed to avoid overpayment for the service provided. After the code was approved by CPT, CMS

assigned a 90 day global period and on that basis a survey was performed to determine a physician work value. The survey results were reviewed by members of the AAO Health Policy Committee (HPC) experienced in RUC methodology and it was apparent that there were issues with the surveys primarily related to the assigned 90-day global period.

The membrane component of this device dissolves at about 10 days and the sutures are then removed. Any additional visits in the remaining 90 day global period are related to treatment of the underlying disease and not to the procedure itself. The number and intensity of the visits would be uncertain and depend primarily on the severity of the disease process itself and totally unrelated to the procedure that was performed. Including visits related to care for the disease process in the global payment for a procedure is inconsistent with our understanding of the intent of the global procedural payment system. CMS allowed the global period to be reduced for CPT 65855 *(trabeculoplasty by laser surgery)* during the second 5 Year Review because the care provided after the initial recovery from the procedure was related to treatment of the underlying disease. The global for prostate needle biopsy was also reduced by CMS and the RUC using similar logic. We feel that the global for this code should be reduced using the same reasoning.

We attempted to communicate with CMS to raise this issue but did not receive a response. We also notified the RUC of the problem and the suggestion was made to come to the RUC with a presentation that was based on a more appropriate global period and allow the RUC to evaluate the presentation and CMS to hear the argument. The HPC convened an expert panel with members familiar with the process and the specific procedure and debated whether the global should be 000 or 10 days. It was felt that a case could be made for both, but that the typical patient would require 2 postoperative visits directly related to the procedure, one at day 1 and another at about 10 days for the physician to remove the sutures and evaluate the healing. A 10 day global period with postoperative 2 visits was determined to be the most appropriate. It was also determined that this procedure, unlike the office based 65XX1, would likely be done in either the facility or office setting and would be associated with an EM visit on the day of the surgery.

The expert panel elected to use a building block method to determine the physician work and add in the established work values for the postoperative visits. Two codes were selected to serve as references: 65420 *(removal of pterygium)* WRVU= 4.36 and 65426 *(removal of pterygium, with graft)* WRVU = 6.05. The RUC has previously reviewed 65426 and agreed that its base code of 65420 was appropriately valued and in fact used it to construct the value of 65426 based on its value and the 68371 conjunctival graft harvest code with the pre and post times removed. They are 90 day global codes, but the postoperative number of visits and intensity is the same. The operations are identical except for the additional work of the graft which the committee felt was similar in skill, intensity, iatrogenic risk and physical effort to 67XX2. The intraservice time difference for the two procedures is [47.5 minus 31 = 16.5 minutes] which approximates the value obtained on the survey. Subtracting the work value of 65420 from 65426 gives what we feel is an appropriate value for the 67XX2 code [6.05 minus 4.36] = 1.69 wRVU.

Therefore the AAO recommends the value of 1.69 for the intra-service work for this procedure. The consensus agreement for postoperative care was for one level 3 visit and one level 2 visit during the 10 day global period. The work values for 99212 (0.48), 99213 (0.97) and one half 99238 (0.64) were added to the ISW for a total of 3.78 work RVUs. Following this, small increment was added to the value to account for the pre (23 minutes) and post time (10 minutes) in the service to produce a **recommended physician WRVU of 3.92** for 65779 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) 66999

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

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 6000
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 information from the manufaturer in their CPT application and on knowledge and experience of our expert panel.

Specialty Ophthalmology Frequency 6000 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? 150
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 information from the manufaturer in their CPT application and on knowledge and experience of our expert panel

Specialty Ophthalmology Frequency 1000 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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 65600

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
000, 010, or 090 Day Global Periods
Non Facility Direct Inputs

CPT Long Descriptor: 65779- Placement of preserved human amniotic membrane on the ocular surface for wound repair or healing; single layer, sutured

Global Period: The most appropriate global is 10-day/CMS has assigned a 90-day

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

The non- facility practice expense details were discussed by a consensus committee of ophthalmologists representing a variety of practice types and geographic settings.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Clinical staff reviews the chart to be certain that the chart is current and all information is available. The minor surgery room is prepared, making certain needed supplies and equipment are available. Clinical staff assembles lid speculum, gloves, anesthetic drops and antibiotic drops and all other surgical supplies. The tech explains the placement and suturing of the amniotic tissue. Consent documents are signed. The patient is then prepped and positioned. Prepared tissue is removed from its cold storage packing for thawing at room temperature.

Intra-Service Clinical Labor Activities:

The tech opens the outer foil peel-pouch and aseptically presents the inner clear pouch to the sterile field. The ophthalmic tech assists the surgeon in retrieving and preparing the tissue. The surgeon uses two 0.12 forceps to grab the two corners of the membrane while the tech retrieves the backing support from the surgeon. The tech helps ensure that the sticky stromal side is placed down on the area to be grafted. The tech assists the surgeon during the suturing process.

Post-Service Clinical Labor Activities:

Clinical staff ensures that the minor surgery room and all equipment is cleaned, cared for and stored.

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation						
2				65778		65779	
3	"Feb 2010			Placement of preserved human amniotic membrane on the ocular surface for wound repair or healing;		Placement of preserved human amniotic membrane on the ocular surface for wound repair or helaing;	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
5	**GLOBAL PERIOD**			**10**	**N/A**	10	10
6	**TOTAL CLINICAL LABOR TIME**			**27.0**	**0.0**	**112.0**	**68.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**5.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**	**49.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**27.0**	**0.0**	**63.0**	**63.0**
10	PRE-SERVICE						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms						
13	Coordinate pre-surgery services						
14	Schedule space and equipment in facility						5
15	Provide pre-service education/obtain consent						
16	Follow-up phone calls & prescriptions						
17	Other Clinical Activity (please specify)						
18	**End:When patient enters office/facility for surgery/procedure**						
19	SERVICE PERIOD						
20	**Start: When patient enters office/facility for surgery/procedure**						
21	**Pre-service services**						
22	Greet Patient and Provide Gowning, Assure Appropriate Medical Records Are Available	L038A	Comt/Cot/RN/ CST			3	
23	Obtain vital signs	L038A	Comt/Cot/RN/ CST			3	
24	Provide pre-service education/obtain consent	L038A	Comt/Cot/RN/ CST			5	
25	Prepare room, equipment, supplies	L038A	Comt/Cot/RN/ CST			2	
26	Setup scope (non facility setting only)	L038A	Comt/Cot/RN/ CST			5	
27	Prepare and position patient/ monitor patient/ set up IV	L038A	Comt/Cot/RN/ CST			2	
28	Sedate/apply anesthesia						
29	**Intra-service**						
30	Assist physician in performing procedure					16	
31	**Post-Service**						
32	Monitor pt following service/check tubes, monitors, drains						
33	Clean room/equipment by physician staff	L038A	Comt/Cot/RN/ CST			3	
34	Clean Scope						
35	Clean Surgical Instrument Package	L038A	Comt/Cot/RN/ CST			10	
36	Complete diagnostic forms, lab & X-ray requisitions						
37	Review/read X-ray, lab, and pathology reports						
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
39	Discharge day management						
40	Other Clinical Activity (please specify)						
41	**End: Patient leaves office**						
42	POST-SERVICE Period						
43	**Start: Patient leaves office/facility**						
44	Conduct phone calls/call in prescriptions						
45	*Office visits*						
46	*List Number and Level of Office Visits*						
47	99211 16 minutes		16				
48	99212 27 minutes	L038A	27	1		1	1
49	99213 36 minutes	L038A	36			1	1
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	Other						
53							
54	*Total Office Visit Time*			**27**	**0**	**63**	**63**
55	Other Activity (please specify)						
56	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
2				65778		65779	
3	"Feb 2010			Placement of preserved human amniotic membrane on the ocular surface for wound repair or healing;		Placement of preserved human amniotic membrane on the ocular surface for wound repair or healing;	
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility	Facility
57	MEDICAL SUPPLIES	CMS Code	Unit				
58	Pack, ophthalmology visit(no dilation)	SA050	item			3	2
59	human amniotic membrane allograft					1	
60	human amniotic membrane allograft mounted on a non-absorbable self-retaining ring			1			
61	gloves, sterile,pr	SB024	pair			2	
62	suture, 10-0 nylon	SF049	item			1	
63	xylocaine, cc	SH047	ml			5	
64	Balanced Salt Solution (BSS) 15 ml	SH078	item			1	
65	needle 27 ga	SC029	item			1	
66	needle 20 ga	SC029	item			1	
67	syringe, 5cc	SC057	item			1	
68	Microsponge, cellulose (10pack)	SG085	item			1	
69	Eye pad, sterile	SG046	item			1	
70	Pack, cleaning surgical instruments	SA043	item			1	
71	Drape, sterile	SB010	item			1	
72	Equipment	CMS Code	Utilization Percentage				
73	instrument pack, basic	EQ137				28	
74	Lane, screening	EL006		27		102.0	63
75	operating microscope	EQ183				24	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2010

Open Angle Glaucoma Procedures

In February 2010, the CPT Editorial Panel converted two Category III codes to Category I codes that describe a new technique for the surgical treatment of glaucoma that is unresponsive to medical therapy.

66174 ***Transluminal dilation of aqueous outflow canal; without retention of device or stent***
The RUC reviewed the survey results from 42 physicians familiar with this new surgical treatment, and gained insight from the specialty regarding the typical patient service for CPT code 66174. The RUC agreed with the specialty with the reduction of 9 minutes of evaluation time from the RUC standard pre-service package of a facility based straightforward patient and procedure with sedation and anesthesia to reflect the typical patient service. The RUC determined the typical physician time for CPT code 66174 would have a total of 16 minutes pre-service, 60 minutes intra-service, and total time of 215 minutes. The RUC also agreed that the physician work value must be between the specialty's 25th percentile survey result of 14.00 work RVUs and its low of 8.00 work RVUs to place it in the proper rank order amongst similar services. The RUC reviewed the following services while valuing 66174:

27027 *Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle), unilateral* (Work RVU = 13.04, 60 minutes intra-service time, total time 359)
38745 *Axillary lymphadenectomy; complete* (Work RVU = 13.87, intra-service time 90 minutes, total time 270.5 minutes)
44300 *Placement, enterostomy or cecostomy, tube open (eg, for feeding or decompression) (separate procedure)* (Work RVU = 13.75), 60 minutes intra-service, total time 389 minutes)
59100 *Hysterotomy, abdominal* (eg, for hydatidiform mole, abortion) (Work RVU = 13.37, 60 minutes of intra-service, total time 329)
65850 *Trabeculotomy ab externo* (Work RVU = 11.39, 60 minutes intra-service, total time 233)

The RUC agreed that new code 66174 was similar to code 65850 in its complexity, however 66174 requires more time and intensity. A building block valuation was developed beginning with the physician work of 65850 of 11.39 work RVUs and then adjusted for the level and number of post operative visits to arrive at a relative work value of 12.85. The RUC reviewed the reference codes above and agreed that 27027, with identical intra-time and analogous physician work, should be valued higher due to the total time disparities.

This recommended value, when compared with these references, provides proper rank order. **The RUC recommends a relative work value of 12.85 for 66174.**

66175- ***Transluminal dilation of aqueous outflow canal; with retention of device or stent***
The RUC reviewed the survey results from 46 physicians familiar with this new surgical treatment. The RUC reviewed code 66175 in relation to 66174 and agreed that proper rank order would necessitate 66175 to be greater than 66174, as 66175 requires the retention of a device or stent. The RUC agreed with the specialty with the reduction of 9 minutes of evaluation time from the RUC standard pre-service package of a facility based straightforward patient and procedure with sedation and anesthesia to reflect the typical patient service. The RUC determined the typical physician time for CPT code 66174 would have a total of 16 minutes pre-service, 60 minute intra-service, and total time of 222.5 minutes. The RUC agreed that an additional increment of work added to the work of 66174 would provide for the proper value for 66175. The RUC added the additional 8 minutes of intra-service work required for 66175 to arrive at a work RVU of 13.60 (intra-service work per unit of time of 0.10 x 7.5 minutes = 0.75 RVUs), (12.85 + 0.75 = 13.60). In addition, the RUC reviewed two additional services which have similar work and physician time, these codes are:

38760 *Inguinofemoral lymphadenectomy, superficial, including Cloquets node (separate procedure)* (Work RVU = 13.62, intra-service time 70 minutes, total time 271 minutes)

43605 *Biopsy of stomach; by laparotomy* (Work RVU = 13.72, intra-service time 60 minutes, total time 402 minutes) and agreed that each service has analogous physician work and intensity and should be valued similarly.

The RUC recommends a relative work value of 13.60 for 66175.

372

New Technology
The RUC recommends that 66174 and 66175 be placed on the new technology/new service list.

Practice Expense: The RUC recommends the standard 090 global direct practice expense inputs for CPT codes 66174 and 66175 as they are services performed only in the facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
66150		Fistulization of sclera for glaucoma; trephination with iridectomy	090	10.53 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
66170		trabeculectomy ab externo in absence of previous surgery (For trabeculotomy ab externo, use 65850) (For repair of operative wound use 66250) ~~(For dilation of Schlemm's Canal with or without retention of device, see 0176T, 0177T)~~	090	15.02 (No Change)
●66174	GG1	Transluminal dilation of aqueous outflow canal; without retention of device or stent	090	12.85
●66175	GG2	with retention of device or stent	090	13.60
Category III				
D 0176T		~~Transluminal dilation of aqueous outflow canal; without retention of device or stent~~		N/A
D 0177T		~~with retention of device or stent~~ (0176T, 0177T have been deleted. To report, see 66174, 66175)		N/A

373

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:66174 Tracking Number GG1 Specialty Society Recommended RVU: **15.00**

Global Period: 090 RUC Recommended RVU: **12.85**

CPT Descriptor: Transluminal dilation of aqueous outflow canal; without retention of device or stent

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male presents with a five-year history of chronic open angle glaucoma with intraocular pressure uncontrolled in the right eye. Visual field testing of the right eye reveals progressive glaucomatous damage

Percentage of Survey Respondents who found Vignette to be Typical: 90%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 24% , In the ASC 76%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , 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.64%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 64%

Is moderate 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)? Yes

Description of Pre-Service Work: The physician reviews the patient history and confirms the eye for surgery. Additional counseling about the treatment planned is performed.

Description of Intra-Service Work: Periocular anesthesia is administered. Corneal traction sutures are placed. The sclera is exposed through a 6 mm conjunctival incision. A limbal-based superficial sclera flap, approximately 4 mm in width and 4 mm in length, is made to a depth of one-third scleral thickness, or approximately 300 microns. A second scleral flap is made directly under the superficial flap, approximately 0.5 mm anterior to the margin of the superficial flap, to a depth approximately 100 microns above the level of the ciliary body.

The inner scleral flap is dissected from the anterior up to the aqueous outflow canal (Schlemm's Canal), exposing and de-roofing the canal. The scleral flap is progressively dissected to expose Descemet's membrane to form a window. The second inner flap is excised at the anterior junction. The ostia of the canal are dilated with Balanced Salt Solution and a paracentesis is performed.

A flexible microcatheter is inserted into the canal and advanced up to 360°. During the retraction of the microcatheter, a viscoelastic is injected throught the catheter into the canal in order to dilate the canal and facilitate microcatheter removal.

The microcatheter is removed from the canal and the outer scleral flap and conjunctiva are sutured closed to seal the surgical site.

Description of Post-Service Work: The operative note is completed. Post-op instructions are reviewed. Post-operative pain control and ophthalmic medications are discussed. Post-operative visits are completed at the appropriate intervals. At each visit the postoperative visit ophthalmic medications are adjusted, the vision and the intraocular pressure assessed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Stephen A. Kamenetzky, M.D. and Michael Stiles, M.D.				
Specialty(s):	Ophthalmology/Glaucoma				
CPT Code:	66174				
Sample Size:	298	**Resp N:** 42	**Response:** 14.0 %		
Sample Type:	Convenience **Additional Sample Information:** A sample of ophthalmologists known to have been trained in this procedure as well as a random sample from the American Glaucoma Society was drawn for this survey.				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.50**	5.00	50.00
Survey RVW:	8.00	14.00	**16.00**	16.88	23.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	20.00	46.00	**60.00**	75.00	90.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**211.00**	99211x **0.00** 12x **6.00** 13x **5.00** 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-FAC Straightforw Pat Procedure(w sedate/anes)

CPT Code:	66174	**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:		**10.00**	**19.00**	**-9.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**110.00**	99211x **0.00** 12x **4.00** 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? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66180	090	16.30	**RUC Time**

CPT Descriptor Aqueous shunt to extraocular reservoir (eg, Molteno, Schocket, Denver-Krupin)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
21048	090	14.71	**RUC Time**	203

CPT Descriptor 1 Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19303	090	15.85	**RUC Time**	20,714

CPT Descriptor 2 Mastectomy; simple, complete

ther Reference CPT Code	Global	Work RVU	Time Source
65756	090	16.84	**RUC Time**

CPT Descriptor Keratoplasty (corneal transplant); endothelial

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 54.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 66174**	**Key Reference CPT Code: 66180**	**Source of Time RUC Time**
Median Pre-Service Time	16.00	29.00	
Median Intra-Service Time	60.00	84.00	
Median Immediate Post-service Time	10.00	23.00	
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	110.0	126.50	
Prolonged Services Time	0.0	0.00	
Median Total Time	**215.00**	**262.50**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.05	3.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.95	3.81
Urgency of medical decision making	3.52	3.57
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.86	4.05
Physical effort required	4.29	3.71
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.14	4.14
Outcome depends on the skill and judgment of physician	4.81	4.19
Estimated risk of malpractice suit with poor outcome	3.81	3.86

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.76	3.57
Intra-Service intensity/complexity	4.67	4.05
Post-Service intensity/complexity	3.67	3.57

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 Val Recommendations for the appropriate formula and format.*

This code was brought to CPT by industry and describes a new technique for the surgical treatment of glaucoma that is unresponsive to medical therapy. The procedure involves threading a microcanula through Schlemm's Canal (diameter 200 μm) to dilate the canal and improve aqueous outflow and lower intraocular pressure. It has the advantage of lowering the intraocular pressure without creating an external drainage site. \t this time it is performed predominantly by ophthalmologists who are sub-specialists in glaucoma.

Survey responses were obtained from 42 individuals (14%) and 90% felt that the vignette accurately described the typical patient. **The 25th percentile in the survey was 14.00 WRVU and the median 16.00.** Median intra-service time was 60 minutes. The primary reference code chosen was 66180 *AQUEOUS SHUNT TO EXTRAOCULAR RESERVOIR (EG, MOLTENO, SCHOCKET, DENVER-KRUPIN)* which has a WRVU 0f 16.30. This code was reviewed by the RUC during the First Five Year Review in 1995.

An expert panel of ophthalmologists familiar with RUC methodology and the procedure reviewed the survey results. The panel felt that Pre-Service package 1B was the correct choice. The panel also reviewed the post-operative visit data from the survey and agreed that 6 post-operative visits during the 90-day global period were required: two 99213 and four 99212. Close monitoring of the operative site for obstruction to aqueous outflow and frequent pressure measurements are necessary for the care of these patients to allow detection and treatment of pressure spikes which can lead to further damage of the optic nerve.

The intra-service time for the reference code (66180) is longer than for the 66174, but the survey participants indicated that the technical skill and physical effort were also higher. They indicated that the overall intra-operative intensity and the psychological stress related to the outcome being dependent on the skills of the physician were greater than the reference code as well. The number of post-operative visits is the same although the levels of the visits are slightly different.

After considering all the variables and using magnitude estimation to consider the differences between the reference code and the surveyed code, the panel felt that the proper WRVU for the 66174 was between the 25th percentile and the median. The society therefore recommends a **WRVU of 15.00**.

,here are several RUC-valued codes with similar intra-service times that have WRVU values in this range. CPT 65756 *Keratoplasty (corneal transplant); endothelial,* recently RUC reviewed has a WRVU of 16.84 and similar pre-, intra- and post-times, but is technically more difficult. CPT 66982 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure)...complex,* has a WRVU of 15.02 and also has similar times and post-operative follow up care.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each 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) Category III code 0176T

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

Specialty Ophthalmology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimated

Specialty Ophthalmology Frequency 2500 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? 500
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimated

Specialty Ophthalmology Frequency 500 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 67121

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:66175 Tracking Number GG2 Specialty Society Recommended RVU: **15.75**

Global Period: 090 RUC Recommended RVU: **13.60**

CPT Descriptor: Transluminal dilation of aqueous outflow canal; with retention of device or stent

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male presents with a five-year history of chronic open angle glaucoma with intraocular pressure uncontrolled in the right eye. Visual field testing of the right eye reveals progressive glaucomatous damage

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 63%

Is moderate 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)? Yes

Description of Pre-Service Work: The physician reviews the patient history and confirms the eye for surgery. Additional counseling about the treatment planned is performed.

Description of Intra-Service Work: Periocular anesthesia is administered. Corneal traction sutures are placed. The sclera is exposed through a 6 mm conjunctival incision. The sclera is exposed at the desired surgical site. A limbal-based superficial scleral flap, approximately 4 mm in width and 4 mm in length, is made to a depth of one-third scleral thickness, or approximately 300 microns. A second scleral flap is made directly under the superficial flap, approximately 0.5 mm anterior to the margin of the superficial flap, to a depth approximately 100 microns above the level of the ciliary body.

The inner scleral flap is dissected from the anterior up to the aqueous outflow canal (or Schlemm's Canal), exposing and de-roofing the canal. The scleral flap may be progressively dissected to expose Descemet's membrane to form a window. The second inner flap is excised at the anterior junction. The ostia of the canal are dilated with Balanced Salt Solution and paracentesis is performed.

A flexible microcatheter is inserted into the canal and advanced up to 360°. With the microcatheter in place, a device (eg, flexible stent, suture) is attached to the distal tip of the microcatheter, and is positioned into the canal as the microcatheter is withdrawn from Schlemm's canal. As the microcatheter is withdrawn, viscoelastic material is injected into the canal

through the microcatheter in order to dilate the canal and facilitate its removal and placement of the stent. Once the flexible microcatheter is removed from the canal the stent is left in place within the canal. The stent is then tensioned to remain within the canal, and to facilitate aqueous flow through the trabecular meshwork.

The outer scleral flap and conjunctiva are sutured closed to seal the surgical site and protect the stent.

Description of Post-Service Work: The operative note is completed. Post-operative instructions are reviewed. Post-operative pain control and ophthalmic medications are discussed. Post-operative visits are completed at the appropriate intervals. At each visit the postoperative medications are adjusted, the vision and the intraocular pressure assessed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Stephen A. Kamenetzky, M.D. and Michael Stiles, M.D.				
Specialty(s):	Ophthalmology/Glaucoma				
CPT Code:	66175				
Sample Size:	298	**Resp N:** 46	**Response:** 15.4 %		
Sample Type:	Convenience **Additional Sample Information:** A sample of ophthalmologists known to have been trained in this procedure as well as a random sample from the American Glaucoma Society was drawn for this survey.				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**5.00**	14.00	50.00
Survey RVW:	8.00	15.00	**16.48**	18.00	25.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	20.00	60.00	**67.50**	90.00	120.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**211.00**	99211x **0.00** 12x **6.00** 13x **5.00** 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-FAC Straightforw Pat Procedure(w sedate/anes)

CPT Code:	66175	**Recommended Physician Work RVU: 15.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**19.00**	**-9.00**
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:		**67.50**		

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0**
Office time/visit(s):	**110.00**	99211x **0.00** 12x **4.00** 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
66180	090	16.30	**RUC Time**

CPT Descriptor Aqueous shunt to extraocular reservoir (eg, Molteno, Schocket, Denver-Krupin)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
21048	090	14.71	**RUC Time**	203

CPT Descriptor 1 Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19303	090	15.85	**RUC Time**	20,714

CPT Descriptor 2 Mastectomy; simple, complete

Other Reference CPT Code	Global	Work RVU	Time Source
65756	090	16.84	**RUC Time**

CPT Descriptor Keratoplasty (corneal transplant); endothlial

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

Number of respondents who choose Key Reference Code: 29 **% of respondents:** 63.0 %

TIME ESTIMATES (Median)	CPT Code: 66175	Key Reference CPT Code: 66180	Source of Time RUC Time
Median Pre-Service Time	16.00	29.00	
Median Intra-Service Time	67.50	84.00	
Median Immediate Post-service Time	10.00	23.00	
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	110.0	126.50	
Prolonged Services Time	0.0	0.00	
Median Total Time	**222.50**	**262.50**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.90	3.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.24	4.14
Urgency of medical decision making	3.55	3.76
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.93	4.21
Physical effort required	4.45	3.90
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.17	4.34
Outcome depends on the skill and judgment of physician	4.79	4.31
Estimated risk of malpractice suit with poor outcome	3.79	3.86

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.73	3.62
Intra-Service intensity/complexity	4.90	4.17
Post-Service intensity/complexity	3.62	3.66

Additional Rationale and Comments

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 Recommendations for the appropriate formula and format.*

This code was brought to CPT by industry and describes a new technique for the surgical treatment of glaucoma that is unresponsive to medical therapy. It has the advantage of lowering the intraocular pressure

without creating an external drainage site. The work for this service is initially identical to that for CPT 66174 (which was also surveyed). The procedure involves threading a microcannula through Schlemm's canal (diameter 200 µm) to dilate the canal and improve aqueous outflow and lower intraocular pressure. Then a suture stent is attached to the cannula and threaded through Schlemm's canal as the cannula is withdrawn. The suture is tensioned, and tied to preserve the dilation of the canal and outflow of aqueous. At this time this procedure is performed predominantly by ophthalmologists who are sub-specialists in glaucoma.

Survey responses were obtained from 46 individuals (15%) and 87% felt that the vignette accurately described the typical patient. **The 25th percentile in the survey was 15.00 WRVU and the median 16.48.** Median intra-service time was 67.5 minutes. The primary reference code chosen was 66180 *AQUEOUS SHUNT TO EXTRAOCULAR RESERVOIR (EG, MOLTENO, SCHOCKET, DENVER-KRUPIN)* which has a WRVU 0f 16.30. This code was reviewed by the RUC during the First Five Year Review in 1995.

An expert panel of ophthalmologists familiar with RUC methodology and the procedure reviewed the survey results. The panel felt that Pre-Service package 1B was the correct choice. The panel also reviewed the post-operative visit data from the survey and agreed that 6 post-operative visits during the 90-day global period were required: two 99213 and four 99212. This is the same number and type of visits suggested for 66174. Close monitoring of the operative site for obstruction to aqueous outflow and frequent pressure measurements are necessary for the care of these patients to allow detection and treatment of pressure spikes which can lead to further damage of the optic nerve.

The intra-service time for the reference code (66180) is longer than for the 66175, but the survey participants indicated that the technical skill and physical effort were also higher for the reference code. They indicated that the overall intra-operative intensity and the psychological stress related to the outcome being dependent on the skills of the physician were greater than the reference code as well. The survey participants rated all of the intensity measures about the same as for 66174 with the exception of "outcome depends on skill and judgment of physician" where 66175 measured 4.90 and XX1 4.67. 66175 was likely ranked higher because of the added physician intra-service steps of properly tensioning and tying the intra-canalicular suture. The number of post-operative visits is the same as for the reference code although the levels of the visits are slightly different.

After considering all the variables and using magnitude estimation to consider the differences between the reference code and the surveyed code, the panel felt that the proper WRVU for the 66174 was between the 25th percentile and the median. The society therefore recommends a **WRVU of 15.75**. This is .75 WRVU higher than the society recommended for 66174 with an intra-service time that is 7.5 minutes longer. The difference is the time needed to thread the suture through Schlemm's canal (diameter 200 µm), properly tension it and then maintain the tension while tying. This added step is critical to the success of the procedure even though most of the overall work of the procedure is in gaining access to the canal itself.

There are several RUC-valued codes with similar intra-service times that have WRVU values in this range. CPT 65756 *Keratoplasty (corneal transplant); endothelial,* recently RUC reviewed has a WRVU of 16.84 and similar pre-, intra- and post-times, but is technically more difficult. CPT 66982 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure)...complex,* has a WRVU of 15.02 and has similar times and post-operative follow up care.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Category III code 0177T

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

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1250
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimated

Specialty Ophthalmology Frequency 1250 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? 250
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimated

Specialty Ophthalmology Frequency 250 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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 67570

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

	A	B	C	D	E	F	G
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**66174**		**66175**	
2	**Meeting Date: April 2010**			**Transluminal dilation of aqueous outflow canal; without retention of device or stent**		**Transluminal dilation of aqueous outflow canal; with retention of device or stent**	
3	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**N/A**	**90**	N/A	90
5	**TOTAL CLINICAL LABOR TIME**			**0.0**	**246.0**	**0.0**	**246.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**60.0**	**0.0**	**60.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**6.0**	**0.0**	**6.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**180.0**	**0.0**	**180.0**
9	**PRE-SERVICE**						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms		L038A		**5**		5
12	Coordinate pre-surgery services		L038A		**20**		20
13	Schedule space and equipment in facility		L038A		**8**		8
14	Provide pre-service education/obtain consent		L038A		**20**		20
15	Follow-up phone calls & prescriptions		L038A		**7**		7
16	Other Clinical Activity (please specify)						
17	**End:When patient enters office/facility for surgery/procedure**						
18	**SERVICE PERIOD**						
19	**Start: When patient enters office/facility for surgery/procedure**						
20	**Pre-service services**						
21	Review charts						
22	Greet patient and provide gowning						
23	Obtain vital signs						
24	Provide pre-service education/obtain consent						
25	Prepare room, equipment, supplies						
26	Setup scope (non facility setting only)						
27	Prepare and position patient/ monitor patient/ set up IV						
28	Sedate/apply anesthesia						
29	**Intra-service**						
30	Assist physician in performing procedure						
31	**Post-Service**						
32	Monitor pt. following service/check tubes, monitors, drains						
33	Clean room/equipment by physician staff						
34	Clean Scope						
35	Clean Surgical Instrument Package						
36	Complete diagnostic forms, lab & X-ray requisitions						
37	Review/read X-ray, lab, and pathology reports						
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
39	Discharge day management 99238 --12 minutes		L038A		**6**		**6**
40	Other Clinical Activity (please specify)						
41	**End: Patient leaves office**						
42	**POST-SERVICE Period**						
43	**Start: Patient leaves office/facility**						
44	Conduct phone calls/call in prescriptions						
45	*Office visits.*						
46	*List Number and Level of Office Visits*						
47	99211 16 minutes		16				
48	99212 27 minutes		27		**4**		**4**
49	99213 36 minutes		36		**2**		**2**
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	Other						
53							
54	*Total Office Visit Time*			**0**	**180**	**0**	**180**
55	Other Activity (please specify)						
56	**End: with last office visit before end of global period**						
57	**MEDICAL SUPPLIES**						
58	Ophthalmology visit package	SA082			**6**		**6**
59							
60	**Equipment**						
61	Exam Lane	EL005			**72**		**72**

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2009

In Situ Hybridization

CPT created two new codes to describe fluorescent in situ hybridization (FISH), a diagnostic technique used to aid in the detection of certain cancers. Codes 88120 and 88121 were specifically created to describe quantitative or semi-quantitative in situ hybridization morphometric analyses by manual and computer-assisted methodologies.

88120
The RUC reviewed the survey results for code 88120 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual* and agreed with the specialty society that the respondents inappropriately included 10 minutes total in the pre-service and immediate post-service for this XXX-global period service instead of accounting for it all in the intra-service period. Therefore, the RUC determined that 30 minutes intra-service/total time appropriately accounts for the time required to perform this procedure. The RUC compared 88120 to key reference service 88365 *In situ hybridization (eg, FISH), each probe* (work RVU = 1.20 and 40 minutes intra-service time) and agreed with the specialty society that the median work RVU of 1.40 was too high because the survey respondents overestimated the intensity required to perform 88120 since it is a quantitative service versus 88365 which is qualitative. The specialty society recommends and the RUC agrees that the survey 25th percentile work RVU of 1.20 appropriate accounts for the physician work required to perform this service. **The RUC recommends a work RVU of 1.20 for code 88120.**

391

88121
The RUC reviewed the survey results for code 88121 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology* and agreed with the specialty society that the respondents inappropriately included 10 minutes total in the pre-service and immediate post-service for this XXX-global period service instead of accounting for it all in the intra-service period. Therefore, the RUC determined that 25 minutes intra-service/total time appropriately accounts for the time required to perform this procedure.

The RUC compared 88121 to key reference service 88365 *In situ hybridization (eg, FISH), each probe* (work RVU = 1.20 and 40 minutes intra-service time) and 88120, and agreed with the specialty society that the median work RVU of 1.20 was too high. Code 88121 requires slightly less work than 88120 because the physician is not performing the screening for 88121, it is an automated

computer-assisted screen. The RUC compared 88121 to similar service 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* (work RVU = 1.00 and 20 minutes intra-service time) to further support a work RVU of 1.00 for code 88121. **The RUC recommends a work RVU of 1.00 for code 88121.**

Practice Expense
The RUC reviewed the direct practice expense inputs and made minor adjustments to the clinical labor, supplies and equipment inputs.

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. Approximately 47% of the utilization for 88368 will now be reported under code 88120 and 69% of the utilization for 88367 will now be reported under code 88121, since the new codes account for approximately 4 probes, whereas 88367 and 88368 describe each probe.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•88120	D1	Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual	XXX	1.20
•88121	D2	using computer-assisted technology (For morphometric in situ hybridization on cytologic specimens other than urinary tract, see 88367, 88368) (For more than 5 probes, use 88399)	XXX	1.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
88367		Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; using computer-assisted technology	XXX	1.30 (No Change)
88368		manual (For morphometric in situ hybridization evaluation of urinary tract cytologic specimens, see 88120, 88121)	XXX	1.40 (No Change)

393

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:88120 Tracking Number D-1 Specialty Society Recommended RVU: **1.20**
Global Period: XXX RUC Recommended RVU: **1.20**

CPT Descriptor: Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual

(For morphometric in situ hybridization on cytologic specimens other than urinary tract, see 88367, 88368)

(For more than 5 probes, use 88399)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old man with a past medical history of urothelial carcinoma in situ (CIS) of the bladder has been treated with Bacillus Calmette-Guerin (BCG) therapy. His most recent urine cytology exam showed "atypical urothelial cells." To discriminate between recurrent carcinoma and BCG therapy reactive changes, the patient's urologist submits a fresh urine and orders evaluation for aneuploidy by FISH for chromosomes 3, 7, 17, and the 9p21 locus.

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

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

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

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work:

Description of Intra-Service Work: After a slide from the urine sediment is prepared, the sample is hybridized with four probes directed at the centromeres of chromosomes 3, 7, 17 and the 9p21 locus, respectively. The pathologist, using a fluorescent microscope, counts the signals from each of these 4 probes in each urothelial cell analyzed. There are two fluorescent controls which must be reviewed by the pathologist: a normal control which is from a cell line that does not have any DNA abnormalities and an aneuploid cell line which shows polysomy. Prior to beginning the counting on th patient's sample the pathologist may review the original atypical cytology slide, if available, under light microscopy determine the shape and size of the abnormal nuclei compared to the normal urothelial nuclei. The pathologist also assesses the background for inflammatory and squamous epithelial cells to avoid counting these nuclei. Next, the patient's hybridization preparation is evaluated by fluorescence microscopy using the DAPI filter (di-amindino 2-phenylindole, a DNA fluorescent stain) to scan the slide for the abnormal nuclei. When abnormal nuclei are detected under DAPI, the

pathologist cycles through each of four filters (a red filter for the probe to centomere of chromosome 3, a green filter for the probe to centromere of chromosome 7, an aquamarine filter for the probe for centromere of chromosome 17 and a yellow filter for a probe to the 9p21 gene locus). Each DNA probe has a different chomophore or color. By using single band-pass filters, only one probe is visible at a time and the number of signals from that probe can be counted in a nucleus. Because these are completely intact nuclei and therefore 3-dimensional, the pathologist must focus up and down to be sure he/she is observing all the signals for that probe in that nucleus. The number of signals is recorded on a worksheet and the process repeated for the other 3 filters or probes. The pathologist then returns to the DAPI view and scans for the next abnormal appearing nucleus. The counting is repeated as described and results recorded for each probe in each nucleus. At least twenty five abnormal appearing nuclei are counted. The pathologist's count will continue, stopping only after at least 4 cells show polyploidy with at least 2 of the 3 centromeric probes, or 12 cells show homozygous deletion of 9p21, or the entire sample has been analyzed. The pathologist selects one or two representative cells to take a digital fluorescence micrograph, a regulatory requirement. The pathologist then transfers these images to the laboratory information system for later inclusion in the report. From the probe signal counts recorded on the worksheet and micrographs the pathologist prepares the report.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2009				
Presenter(s):	Dr. Jonathan Myles				
Specialty(s):	College of American Pathologists				
CPT Code:	88120				
Sample Size:	500	**Resp N:**	33	**Response:** 6.6 %	
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	10.00	**50.00**	170.00	400.00
Survey RVW:	0.73	1.20	**1.40**	2.80	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:	4.00	12.00	**20.00**	30.00	60.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
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:	88120	**Recommended Physician Work RVU: 1.20**		
		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:
's this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88365	XXX	1.20	**RUC Time**

CPT Descriptor In situ hybridization (eg, FISH), each probe

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
88333	XXX	1.20	**RUC Time**	40,742

CPT Descriptor 1 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99203	XXX	1.34	**RUC Time**	5,221,086

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care

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:** 63.6 **%**

TIME ESTIMATES (Median)	CPT Code: 88120	Key Reference CPT Code: 88365	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	40.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	**30.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.24	2.24
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.52	2.48
Urgency of medical decision making	1.96	1.90
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.81	2.81
Physical effort required	1.86	1.90
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.10	2.10
Outcome depends on the skill and judgment of physician	2.48	2.43
Estimated risk of malpractice suit with poor outcome	2.10	2.14

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	1.67	1.81
Intra-Service intensity/complexity	2.67	2.62
Post-Service intensity/complexity	1.95	1.95

Additional Rationale and Comments

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 representatives from the general and academic pathology practice settings. The Panel also included a pathologist with a special interest in molecular pathology and 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 1.20.

The Panel took these steps in reaching their conclusion:

1) Reviewed the survey results
2) Compared the recommended RVW, time and intensity/complexity of 88120 to the reference service 88365 *In situ hybridization (eg, FISH), each probe*
3) Compared other services/procedures on the MPC List to the recommended RVW and time of 88120

Review of Survey Results

The Expert Panel felt the survey respondents fairly estimated the physician work time of 30 minutes, but that the survey median RVW of 1.40 was too high. The members were of the opinion that the survey respondents misjudged (overestimated) the intensity of 88120 since it is a quantitative service vs. CPT code 88365 *In situ hybridization (eg, FISH), each probe*, being qualitative. The Panel also looked at other services/procedures with the same total time as the new code, and felt the 25% survey value of 1.20 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) 88368

How often do physicians 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? Sometimes
Specialty	How often?
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 50,000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. In 2006, 44,690 new cases of male urinary bladder cancer were reported and 16,730 new female cases were reported.

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? 26000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This code will be used for coding for UroVysion in situ hybridization studies. Previously these studies were coded using 88368. One unit of service for this code will be used instead of 4 units of service for 88368. Using CMS utilization data, it is estimated that this code will be used approximately 26,000 times per year given historical data. This number may be an underestimate as clinical indications for this procedure have been expanded.

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? (ie. similar work RVU, and specialty) 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:88121 Tracking Number D-2 Specialty Society Recommended RVU: **1.00**
Global Period: XXX RUC Recommended RVU: **1.00**

CPT Descriptor: Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology

(For morphometric in situ hybridization on cytologic specimens other than urinary tract, see 88367, 88368)

(For more than 5 probes, use 88399)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old man with a past medical history of urothelial carcinoma in situ (CIS) of the bladder has been treated with Bacillus Calmette-Guerin (BCG) therapy. His most recent urine cytology exam showed "atypical urothelial cells." To discriminate between recurrent carcinoma and BCG therapy reactive changes, the patient's urologist submits a fresh urine and orders evaluation for aneuploidy by FISH for chromosomes 3, 7, 17, and the 9p21 locus.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

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

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

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work:

Description of Intra-Service Work: After a slide from the urine sediment is prepared, the sample is hybridized with four probes directed at the centromeres of chromosomes 3, 7, 17 and the 9p21 gene locus, respectively.
There are two fluorescent controls which must be reviewed by the pathologist: a normal control which is from a cell line that does not have any DNA abnormalities and an aneuploid cell line which shows polysomy. Prior to beginning the ounting on the patient's sample the pathologist may review the original atypical cytology slide, if available, under light icroscopy to determine the shape and size of the abnormal nuclei compared to the normal urothelial nuclei.

After the hybridization procedure, the patient's slide is placed on an automated device that will scan the entire slide on high magnification. This device usually consists of a fluorescent microscope with motorized slide stage linked to a computer console which contains software to drive the microscope stage and manipulate the fluorescent filters for visualization of the

probe signals on the slide. The software program will locate each nucleus that is stained with DAPI, and attempt to capture images of the stained nucleus, as well as the probe signal pattern for each of the 4 probes. These images are then stored and available for review by the pathologist.

Using the computer assisted system (e.g., BioView), the pathologist can scan and perform an analysis of the entire slid The pathologist will assess all the captured images, including the background for inflammatory and squamous epithelia cells to avoid counting these nuclei. With the use of FDA-approved systems (e.g., Duet/Solo), images of the cells can be taken and placed side by side, then displayed in a tile-like fashion on a computer screen. First, the patient's hybridization slide is evaluated by the pathologist using the DAPI stained images (di-amindino 2-phenylindole, a DNA fluorescent stain) to scan each cell on the slide for abnormal nuclei. When abnormal nuclei are detected under DAPI, the pathologist can then view the probe signal pattern for each of four filters (a red filter for the probe to centromere of chromosome 3, a green filter for the probe to centromere of chromosome 7, an aquamarine filter for the probe to centromere of chromosome 17 and a yellow filter for a probe to the 9p21 gene locus). Each DNA probe has a different chromophore or color. By using filters only one probe is visible at a time, and the number of signals from that probe can be counted in the nucleus. The computer assists in this process, and the number of signals is recorded in the system and the process is repeated for the other 3 filters or probes. The pathologists then returns to the DAPI view and scans for the next abnormal appearing nucleus. The counting is repeated as described and results recorded for each probe in each nucleus. At least 100 nuclei are counted. The pathologist's review will continue, stopping only after at least 4 cells show polyploidy in at least 2 of the 3 centromeric probes, or 12 cells show homozygous deletion of 9p21, or the entire sample has been analyzed. The pathologist selects one or two representative cells to capture a digital fluorescence micrograph, a regulatory requirement. The pathologist then transfers the images to the laboratory information system for later inclusion in the report. From the probe signal counts recorded and micrographs the pathologist prepares the final report.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2009				
Presenter(s):	Dr. Jonathan Myles				
Specialty(s):	College of American Pathologists				
CPT Code:	88121				
Sample Size:	500	**Resp N:**	25	**Response:** 5.0 %	
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	4.00	55.00	**140.00**	250.00	400.00
Survey RVW:	0.60	1.20	**1.20**	1.39	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:	4.00	10.00	**15.00**	30.00	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: Select Pre-Service Package

CPT Code:	88121	**Recommended Physician Work RVU: 1.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**25.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
88365	XXX	1.20	**RUC Time**

CPT Descriptor In situu hybridization (eg, FISH) each probe

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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**	31,223

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
78315	XXX	1.02	**RUC Time**	119,974

CPT Descriptor 2 Bone and/or joint imaging; 3 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: 15 **% of respondents:** 60.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 88121**	**Key Reference CPT Code: 88365**	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	25.00	40.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**25.00**	**40.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.07	2.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.40	2.47
Urgency of medical decision making	1.80	1.73
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.67	2.73
Physical effort required	1.87	1.87
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	1.87	1.93
Outcome depends on the skill and judgment of physician	2.33	2.40
stimated risk of malpractice suit with poor outcome	1.60	1.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.80	1.67
Intra-Service intensity/complexity	2.40	2.47
Post-Service intensity/complexity	1.73	1.67

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value ecommendations 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 representatives from the general and academic pathology practice settings. The Panel also included a pathologist with a special interest in molecular pathology and 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 1.00.

The Panel took these steps in reaching their conclusion:

1) Reviewed the survey results
2) Compared the recommended RVW, time and intensity/complexity of 88121 to the reference service code 88365 *In situ hybridization (eg, FISH), each probe* and,
3) Compared other services/procedures on the MPC List to the recommended RVW and time of 88121

Review of Survey Results

The Expert Panel felt the survey respondents appropriately estimated the total service time of 25 minutes. The survey median and the 25% RVU of 1.20 were considered to be slightly high, and agreed that an RVU of 1.0 was more appropriate. This is comparable to CPT codes 88367 and 88368 where the manual service has both additional time and a higher RVU.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 88367

How often do physicians 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? Sometimes

Specialty How often?

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. In 2006, 44,690 new cases of male urinary bladder cancer were reported and 16,730 new female cases were reported.

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? 26,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This code will be used for UroVysion studies and is currently reported using code 88367. One unit of service will be used for this procedure using the new code compared to 4 units for 88367. Using CMS utilization data, 26000 units of service are estimated for the new code. However, this may underestimate the use of this code in the future as clinical indications for UroVysion have expanded.

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

Do many physicians perform this service across the United States?

---

rofessional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) 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:

88120
Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual

(For morphometric in situ hybridization on cytologic specimens other than urinary tract, see 88367, 88368)

(For more than 5 probes, use 88399)

88121
Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology

(For morphometric in situ hybridization on cytologic specimens other than urinary tract, see 88367, 88368)

(For more than 5 probes, use 88399)

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 included the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings. The workgroup also included a pathologist with a special interest in molecular pathology and who actively performs the surveyed service, since this CPT code represents new technology and this service is not currently performed by most general pathologists.

See Excel spreadsheet for labor, supplies and equipment detail.

	A	B	C	D	E	F	G
1	**AMA Specialty Society RVS Update Committee Recommendation**			**88120**		**88121**	
2							
3	**Meeting Date: October 2009**	**CMS**	**Staff**	**Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual (For morphometric in situ hybridization on cytologic specimens other than urinary tract, see 88367, 88368) (For more than 5 probes, use 88399)**		**Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen using computer-assisted technology (For morphometric in situ hybridization on cytologic specimens other than urinary tract, see 88367, 88368) (For more than 5 probes, use 88399)**	
4	**LOCATION**	**Code**	**Type**	**XXX**	**Facility**	**XXX**	**Facility**
5	**GLOBAL PERIOD**	**XXX**					
6	**TOTAL CLINICAL LABOR TIME**			**102.2**	**0.0**	**52.7**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**43.8**	**0.0**	**30.2**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**49.0**	**0.0**	**17.8**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**9.33**	**0.00**	**4.67**	**0.00**
10	PRE-SERVICE						
11							
12	Retrieve and accession specimen	L033A/L037B		**1.33**		**0.67**	
13	Gather all the relevant slides, prior report, and history on the patient for the pathologist to review to choose the region of interest on the slide	L033A/L037B		**4.00**		**2.00**	
14	Prep work of reagents	L033A		**17.83**		**8.92**	
15	Prepare reagents and equipment Re-cut paraffin blocks and bake slides Deparaffinize, treat with HCL, wash Treat with enzyme, wash and rehydrate. Apply DNA probe mixture to positive, negative control and patient's slide. Allow to hybridize in chamber for 16 hours. Apply DAPI, recoverslip, and label. Deliver slides to pathologist	L037B					
16	UO ThinPrep UroCyte specimen processing and slide preparation for Xmatrix AutoFish	L033A		**9.17**		**9.08**	
17	Slide Pretreatment Manual Assay	Med Tech		**1.33**		**0.67**	
18	Centrifuge, make slide, seal slide	Med Tech		**2.33**		**2.17**	
19	Denaturation of Specimen DNA and Hybridization on the ThermoBrite System	Med Tech		**3.00**		**2.5**	
20	Post-hybridization washes	Med Tech		**4.83**		**4.17**	
21	Load slides on Auto Vysis Scanner, and enter slide IDs Verify controls using fluorescent microscope After pathologist has verified fields of interest, select the fields to be scanned	L037B					
22	Verify controls using fluorescent microscope. Deliver slides to pathologist.	L037B					
23							
24	SERVICE PERIOD						
25							
26	Set-up assay slide analysis system	L045A		**2.67**		**1.33**	
27	Quality appraisal, Assuring appropriate cellularity of specimen and adequacy of staining of all specimens and controls	L045A				**16.50**	
28	Screen specimen slides	L045A		**39.33**			
29	Photograph and print samples	L045A		**7.00**			
30							
31	POST-SERVICE Period						
32							
33	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A/L037B		**4.00**		**2.00**	
34	Dispose of remaining specimens, spent chemicals/ other consumables, and hazardous waste	L033A		**4.33**		**2.17**	
35	Clean room/ equipment following procedure (including any equipment maintenance that must be done after the procedure)	L033A	1	**1**		**0.5**	

	A	B	C	D	E	F	G
1	**AMA Specialty Society RVS Update Committee Recommendation**			**88120**		**88121**	
2							
3	**Meeting Date: October 2009**	**CMS**	**Staff**	**Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual (For morphometric in situ hybridization on cytologic specimens other than urinary tract, see 88367, 88368) (For more than 5 probes, use 88399)**		**Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology (For morphometric in situ hybridization on cytologic specimens other than urinary tract, see 88367, 88368) (For more than 5 probes, use 88399)**	
4	**LOCATION**	**Code**	**Type**	**XXX**	**Facility**	**XXX**	**Facility**
36	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**				
37	gown, staff, impervious (1 gown per staff = 3)	SB027	item	**1.00**		**0.5**	
38	eye shield, splash protection (1 pair eye shield per staff = 3)	SM016	item	**1.00**		**0.5**	
39	gloves, non-sterile, nitrile (9 pairs per batch)	SB023	item	**3.00**		**1.5**	
40	mask, surgical (1 mask per staff = 3)	SB0233	item	**1.00**		**0.5**	
41	Biohazard specimen transport bag	SM008	item	**1.00**		**1.00**	
42	Pipette tips	SL181	item	**2.00**		**1.84**	
43	Non-Gyn Filter unit		item	**0.3**		**0.2**	
44	0 45 µm pore filtration unit		item	**0.7**		**0.3**	
45	50mL centrifuge tube	SL024	item	**3.0**		**3.00**	
46	12-well slides		item	**1.0**		**1.00**	
47	12 mm round glass coverslip	SL030	item	**1.0**		**1.00**	
48	ThinPrep UroCyte filter		item	**1.0**		**1.00**	
49	20ml PreservCyt® solution vial	SL040	item	**1.0**		**1.00**	
50	Humidity cards		item	**0.7**		**0.30**	
51	18 mm coverslip	SL030	item	**1.0**		**1.00**	
52	5mL syringe	SC057	item	**0.3**		**0.20**	
53	Control slides		kit	**0.3**		**0.2**	
54	Bleach cleaning wipe		item	**0.3**		**0.2**	
55	10% Neutral Buffered Formalin	SL070	mL	**4.2**		**2.1**	
56	FISH pre-treatment kit		kit	**0.3**		**0.2**	
57	1N NaOH	SL179	mL	**3.3**		**1.7**	
58	ThinPrep UroCyte Urine Collection Kit		kit	**1.0**		**1.0**	
59	Fresh Fixative (3 1, methanol· acetic acid)		mL	**47.5**		**47.5**	
60	CytoLyt® solution	SL039	mL	**30.0**		**30.0**	
61	95% Ethanol fixative vial		item	**1.0**		**1.0**	
62	1% formaldehyde		mL	**0.3**		**0.2**	
63	70% Ethanol solution	SL190	mL	**66.7**		**33.3**	
64	85% Ethanol solution	SL191	mL	**33.3**		**16.7**	
65	100% Ethanol solution	SL189	mL	**33.3**		**16.7**	
66	Rubber cement	SJ070	mL	**1.0**		**1.0**	
67	UroVysion test kit		assay	**1.7**		**1.3**	
68	Immersion oil	SL080	mL	**0.3**		**0.2**	
69	Distilled or deionized water	SL244	mL	**3.0**		**1.5**	
70	**Equipment**						
71	Vacuum pump	EP042		**0.89**		**0.22**	
72	pH meter	EP030		**2.67**		**0.67**	
73	Centrifuge	EP007		**2.22**		**0.11**	
74	Hood, ventilator with blower	EP019		**5.94**		**8.92**	
75	cytology thinlayer processor (ThinPrep)	EP008		**0.22**		**0.06**	
76	Water bath, FISH procedure, lab	EP054		**2.11**		**1.06**	
77	Microfuge	EP048		**0.11**		**0.03**	
78	ThermoBrite			**94.00**		**26**	
79	Camera			**7.00**		**7.0**	
80	IkoniLan Software					**2.97**	
81	IkoniScope					**2.97**	
82	Microscope, compound	EP024		**1.00**			
83	Olympus BX41 Fluorescent Microscope (without filters or camera)			**1.33**			
84	Filters			**14.00**			

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2010

Evaluation of Fine Aspirate

Due to confusion amongst payers and providers, in February 2010 the CPT Editorial Panel revised the descriptor for 88172 and created a new code, 88177, to report the first evaluation episode and each additional episode of cytopathology evaluation of fine needle aspirate.

88172 Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site

The RUC reviewed the specialty survey results from 107 pathologists for revised code 88172 and agreed with the specialty that the survey respondents overestimated the work value with a median work RVU of 1.20. The RUC compared the physician work to the survey's key reference code 88333 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial* (Work RVU = 1.20, intra-service = 25 minutes) and concurred that although they have similar physician work, the intensity of mental effort, judgment required, and the psychological stress in evaluating specimen adequacy of diagnosis is less in 88172 than in 88333. In addition, the RUC compared the work of the surveyed service to reference code 99408 *Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes* (Work RVU= 0.65 and total time= 20 minutes) and agreed that the services have analogous total time and should be valued similarly. Finally, the RUC looked at 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (Work RVU= 0.73 and total time= 20 minutes) and the RUC agreed that 88172 is a slightly less intense service to perform in comparison to the surveyed code and thereby should be valued slightly lower than this reference code. Considering these comparisons, and in order to maintain work neutrality between 88172 and 88177 the RUC agreed that 0.69 RVUs accurately reflects the amount of work required to perform this service. **The RUC recommends a relative work RVU of 0.69 for CPT code 88172.**

88177 ***Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site***

The RUC reviewed the specialty survey results from 126 pathologists for new code 88177 and agreed that the survey respondents misunderstood the service being examined as the median work RVU of 1.20 RVUs was not reflective of the service and did not maintain rank order with other pathology services. The RUC compared the work of CPT codes 88333 (Work RVU= 1.20) and 88334 (Work RVU = 0.73). The RUC agreed with the specialty that the ratio in physician work between 88333 and 88334 may be applied to

423

the ratio of work between 88172 and 88177. This methodology results in a relative work value of 0.42 for CPT code 88177 ((0.73/1.20) x 0.69 = 0.42. The RUC noted that the value of 0.42 for 88177 maintains work neutrality with the base code, 88172. **The RUC recommends a relative work value of 0.42 for CPT code 88177.**

Practice Expense: The RUC reviewed the direct practice expense inputs for these services and made minor edits to the clinical labor time to reflect the typical patient service.

CPT Assistant Referral: The RUC recommended that a *CPT Assistant* article be published to educate users on the appropriate reporting of codes 88172 and 8817X. The article should also provide 1) a definition of the term "evaluation episode"; 2) vignettes; and 3) discussion of the unique situation when the pathologist is both performing the FNA and making the interpretation.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲88172	JJ1	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy ~~of specimen(s)~~ for diagnosis, first evaluation episode, each site (The evaluation episode represents a complete set of cytologic material submitted for evaluation and is independent of the number of needle passes or slides prepared. A separate evaluation episode occurs if the proceduralist provider obtains additional material from the same site, based on the prior immediate adequacy assessment, or a separate lesion is aspirated)	XXX	0.69
88173		interpretation and report	XXX	1.39 (No Change)
#●88177	JJ2	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation;	XXX	0.42

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure) (When repeat immediate evaluation episode(s) is required on subsequent cytologic material from the same site, eg, following determination the prior sampling that was not adequate for diagnosis, use 1 unit of 88177 for each additional evaluation episode) (Use 88177 in conjunction with 88172)		

425

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:88172 Tracking Number JJ1 Specialty Society Recommended RVU: **0.69**
Global Period: XXX RUC Recommended RVU: **0.69**

CPT Descriptor: Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site

(The evaluation episode represents a complete set of cytologic material submitted for evaluation and is independent of the number of needle passes or slides prepared. A separate evaluation episode occurs if the proceduralist provider obtains additional material from the same site, based on the prior immediate adequacy assessment, or a separate lesion is aspirated)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A fine needle aspiration is being performed for evaluation of a 1.0 cm lung nodule in a 56-year-old male with chronic obstructive pulmonary disease (COPD). The physician is asked to immediately evaluate the smears to determine if the specimen is adequate to make a definitive diagnosis.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

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

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The material obtained from the aspiration is processed as cytologic preparations and presented to the pathologist for immediate evaluation for adequacy. There may be one or more slides stained using Pap, Diff-Quik, or H and E. The pathologist performs a microscopic examination of each slide and determines that either the material is adequate or that additional aspirate material is needed for diagnosis and/or definitive workup. The pathologist communicates this information to the radiologist.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Jonathan L. Myles, MD,FCAP Margaret Havens Neal, MD, FCAP W. Stephen Black-Schaffer, MD, FCAP				
Specialty(s):	College of American Pathologists, American Society of Cytopathology				
CPT Code:	88172				
Sample Size:	1000	**Resp N:** 107	**Response:** 10.7 %		
Sample Type:	Convenience	**Additional Sample Information:** ASC membership list			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	40.00	**100.00**	200.00	300.00
Survey RVW:	0.45	1.20	**1.20**	1.35	2.50
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	10.00	**20.00**	30.00	45.00

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

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

Specialty Society Recommended Data

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

CPT Code:	88172	**Recommended Physician Work RVU: 0.69**		
		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? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88333	XXX	1.20	**RUC Time**

CPT Descriptor Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial 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
20551	000	0.75	**RUC Time**	201,322

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

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,020,282

CPT Descriptor 2 Ultrasound, abdominal, real time with image documentation; 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: 77 **% of respondents:** 71.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 88172**	**Key Reference CPT Code: 88333**	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	25.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**20.00**	**25.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.49	4.41
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.90	3.83
Urgency of medical decision making	4.60	4.69
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.45	4.32
Physical effort required	3.60	3.54
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.97	4.05
Outcome depends on the skill and judgment of physician	4.67	4.65
stimated risk of malpractice suit with poor outcome	3.99	4.24

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.73	4.13
Post-Service intensity/complexity		

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 ecommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by an Expert Panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

The Expert Panel recommends the RVW value of 0.81.

The Panel took these steps in reaching their conclusion:

1) Reviewed the survey results
2) Compared the recommended RVW, time and intensity/complexity of 88172 to the reference service 8833 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site*
3) Compared 88173 to the recommended RVW and time of 88172

Review of Survey Results

Upon review of the survey results for 88172, the expert panel came to an agreement that since this code is always performed in conjunction with 88173 *Cytopathology, evaluation of fine needle aspirate; interpretation and report*, that the pre and post time of 88172 was duplicative of the work of 88173. Accordingly, it is the recommendation of the panel to delete the 5 minutes of pre-service work and the 10 minutes of post-service work, leaving a total time of 20 minutes intra-service work. Because of the elimination of pre- and post-service time, the panel felt the 25% and median RVW of 1.20 of the survey to be high.

To come to an appropriate RVW, the panel reviewed the intensity of 88172 to that of 88333. The panel indicated that the intensity/complexity measures of 88172 were rated very similar by the survey respondents to the reference service. While the technical skill and the physician effort of 88172 is quite similar to that of 88333 (intraoperative cytology) in that the smears must be prepared and appropriately managed, it was the opinion of the expert panel that the intensity of mental effort, judgment required, and the psychological stress of evaluating for adequacy of diagnosis is less than that of 88333, in which the decision for the appropriate operative procedure and hence the patient outcome in more immediate and qualitatively impacted.

Code 88172 was then compared to the fine needle aspirate interpretive code 88173. The evaluation of the specimen for 88172 is performed during the fine needle aspiration procedure on limited material which requires triage. This rapid determination for adequacy of 88172 is crucial to decision-making process where additional intervention(s) or separate procedure(s) to obtain a diagnostic sample which is sufficient for diagnosis and /or ancillary testing is important. Therefore, the panel felt 88172 to be a more intense service than 88173.

COMPELLING EVIDENCE RATIONALE

Code 88172 meets two criteria for compelling evidence:

One of the criteria for compelling evidence is "Incorrect assumptions that were made in the previous valuation of the service."

It was assumed in the initial valuation of the service that all evaluation episodes obtained from the same site would be of the same value. There was no distinction between the initial episode evaluation and subsequent evaluations from the same site. Code 88172 was previously the only code appropriate for any immediate intra-procedural assessments of adequacy of the cytological material obtained for diagnosis. As described above in the Expert Panel review, with the introduction of 88172, 88172 services are now only initial interpretations, with greater physician work involved than subsequent interpretations (88177) from the same patient site. With the introduction of the appropriately lower-physician-work-valued 88177, budget neutrality in the code family requires corresponding recognition of the greater physician work of the initial interpretation service.

The second criterion for compelling evidence is an anomalous valuation with the code 88333.

The current valuation and intensity of 88172 and 88333 indicates that the 88172 has a disparately low intensity when compared with 88333. While the 88333 code is more intense, both 88172 and 88333 require immediate assessment of a cytologic specimen, and the intensities should be much closer than they currently are.

The proposed valuation of 88172 and 88177 would serve to address this disparity and indicate appropriate relative value.

Code		RVW	Minutes	Ratio
88333	**Current RUC Value & Time**	1.20	25 minutes	

88334	**Current RUC Value & Time**	0.73	20 minutes	0.73/1.20= 0.608
88172	**Proposed Value & Time**	0.80	20 minutes	
88177	**Proposed Value & Time**	0.49	15 minutes	0.49/0.80 = 0.612

SERVICES REPORTED WITH MULTIPLE 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.

REQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 88172

How often do physicians 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? Sometimes

Specialty How often?

Specialty How often?

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

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
ɔecialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
48,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Approximately 2/3 of the current 88172, will be reported as 8817X. The

2008 CMS utlization data shows 143,893 (88172) reported in 2008. Therefore, approximately 1/3 of 143,893 will be reported as 88172 (47,466)

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 88172

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:88177 Tracking Number JJ2 Specialty Society Recommended RVU: **0.42**
Global Period: ZZZ RUC Recommended RVU: **0.42**

CPT Descriptor: Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)
(When repeat immediate evaluation episode(s) is required on subsequent cytologic material from the same site, eg, following determination the prior sampling that was not adequate for diagnosis, use 1 unit of 88177 for each additional evaluation episode)

(Use 88177 in conjunction with 88172)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A fine needle aspiration is being performed for evaluation of a 1.0 cm lung nodule in a 56-year-old male with chronic obstructive pulmonary disease (COPD), closely following a previous aspirate specimen that was found to be not adequate for diagnosis. The physician is asked to immediately evaluate additional smears to determine if the specimen is adequate to make a definitive diagnosis

Percentage of Survey Respondents who found Vignette to be Typical: 99%

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

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

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The pathologist is presented additional cytologic material for immediate evaluation for adequacy. There may be one or more slides stained using Pap, Diff-Quik, or H and E. The pathologist performs a microscopic examination of each slide and determines that either the material is adequate or that additional aspirate material is needed for diagnosis and/or definitive workup. The pathologist communicates this information to the radiologist.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Margaret Havens Neal, MD, FCAP, W. Stephen Black-Schaffer, MD, FCAP				
Specialty(s):	College of American Pathologists, American Society of Cytopathology				
CPT Code:	88177				
Sample Size:	1000	**Resp N:** 126	**Response:** 12.6 %		
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	40.00	**100.00**	250.00	3000.00
Survey RVW:	0.62	1.20	**1.20**	1.30	
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	11.00	**20.00**	30.00	60.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
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: ZZZ Global Code

CPT Code:	88177	**Recommended Physician Work RVU: 0.42**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**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
88333	XXX	1.20	**RUC Time**

CPT Descriptor Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial 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
97110	XXX	0.45	**RUC Time**	2,126,286

CPT Descriptor 1 Fundus photography with interpretation and report

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11719	000	0.17	**Other**	7,382,193

CPT Descriptor 2 Debridement of nail(s) by any method(s); 6 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: 97 **% of respondents:** 76.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 88177**	**Key Reference CPT Code: 88333**	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	25.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
'edian Office Visit Time	0.0	0.00	
. rolonged Services Time	0.0	0.00	
Median Total Time	**15.00**	**25.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.28	4.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.66	3.69
Urgency of medical decision making	4.62	4.72
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.27	4.19
Physical effort required	3.41	3.35
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.94	3.99
Outcome depends on the skill and judgment of physician	4.58	4.56
Estimated risk of malpractice suit with poor outcome	3.94	4.13

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.03	4.11
Post-Service intensity/complexity		

Additional Rationale and Comments

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

Following the survey, the data were reviewed by an Expert Panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

The Expert Panel recommends the RVW value of 0.49.

The Panel took these steps in reaching their conclusion:

1) Reviewed the survey results
2) Compared the recommended RVW, time and intensity/complexity of 88177 to the reference service 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site*
3) Compared the relationship between 88333 and 88334 to that of 88172 and 88177

Review of Survey Results

Code 88177 came in with a median time of 20 intra-service time (total time) and 1.2 RVW. Because 88177 is always performed in conjunction with 88172, the expert panel felt that the time should be decreased since there is a familiarity with the circumstances of the case and the differential diagnosis is more focused based on the material obtained from the first evaluation episode. A 25% decrease in time was thought to be appropriate yielding an intra-service time and total time of 15 minutes.

Additionally, the expert panel indicated that the 25% and the median RVW of 1.20 from the survey data was too high. The expert panel noted that the survey respondents found the intensity of 88177 quite similar to 88333 as with 88172 and 88333. The relationship between 88172 and 88177 is analogous to the relationship between 88333 and 88334, where a first specimen is evaluated and then additional specimens from each additional site are evaluated. Using the ratio between the RVW of 88333 and 88334 (0.73/1.20=0.608) as a proxy for the work differential between 88172 and 88177, an RVW of 0.49 is yielded for 88177 (0.8 x 0.608= 0.4864).

SERVICES REPORTED WITH MULTIPLE 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) 88172

How often do physicians 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? Sometimes

Specialty How often?

Specialty How often?

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

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 97,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Approximately 2/3 of the current 88172, will be reported as 8817X. The 2008 CMS utlization data shows 143,893 (88172) reported in 2008. Therefore, approximately 1/3 of 143,893 will be reported as 88172 (47,466)

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 88291 Did not select reference CPT code since the value was greater than 10% of the recommended value of 8817X

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

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

CPT Long Descriptor: Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site

(The evaluation episode represents a complete set of cytologic material submitted for evaluation and is independent of the number of needle passes or slides prepared. A separate evaluation episode occurs if the proceduralist provider obtains additional material from the same site, based on the prior immediate adequacy assessment, or a separate lesion is aspirated)

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:

Data were developed by CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
-Prepare and assemble cart, markers, stains, coverslips, slides, containers, cytologic fixative and preservative solutions, requisitions, and microscope in preparation for the specimen

Intra-Service Clinical Labor Activities:
-Under direction of the pathologist label and prepare air dried and alcohol fixed smears
-Verify patient, label slides with patient unique identifiers, open stain jars, gauze, prepare folder
-Obtain requisition and assist pathologist with documentation of patient information
-Dry and fix smears and stain with one or more stains as directed by pathologist
-Document findings on requisition and verify with pathologist
-Under direction of the pathologist document, distribute, label, and appropriately preserve material for additional studies and preparations (eg cytospins, cellblock, liquid based preparation, flow cytometry, cytogenetics)

Post-Service Clinical Labor Activities:
-Decontaminate cart and staining area
-Unload refrigerated items, filter or change stains

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

CPT Long Descriptor: Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)
(When repeat immediate evaluation episode(s) is required on subsequent cytologic material from the same site, eg, following determination the prior sampling that was not adequate for diagnosis, use 1 unit of 88177 for each additional evaluation episode)

(Use 88177 in conjunction with 88172)

Global Period: ZZZ

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

Data were developed by CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: N/A

Intra-Service Clinical Labor Activities:
-Prepare slides after verification of patient, label with patient identifiers.
-Assist pathologist with documentation of pt information on requisition
-Dry and fix smears, stain smears with one or more stains as directed by pathologist
-Coverslip and dry slides
-Document findings on form

Post-Service Clinical Labor Activities: N/A

	A	B	C	D	E	F
2	**AMA/Specialty Society RVS Update Committee Recommendation**			88172		88
3	**Meeting Date: April 2010**			Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site		Cytopathology, vaginal (any rep collected in pre automated thin preparation; im cytohistologic s determine adeq diagnosis, each additional evalu same site
4	LOCATION	CMS Code	Staff Type	Non Facility	Facility	Non Facility
5	GLOBAL PERIOD			XXX		ZZZ
6	TOTAL CLINICAL LABOR TIME	LO35A	Labtech /Histo	23		11
7	SUBTOTAL CLINICAL LABOR PER STAFF TYPE					
8	TOTAL PRE-SERV CLINICAL LABOR TIME PER STAFF TYPE	LO35A		1		
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME PER STAFF	LO35A		19		11
10	TOTAL POST-SERV CLINICAL LABOR TIME	LO35A		3		
11	PRE-SERVICE					
12	Prepare cart with markers, stains, coverslips, slides, containers, cytologic fixative and preservative solutions, requisitions, and microscope in preparation for the specimen	LO35A		1		
13	SERVICE PERIOD					
14	Prepare slides after verification of patient, label with patient identifiers Open stain jars, gauze, folder Unload microscope.	LO35A		2		1
15	Obtain requisition, assist pathologist with documentation of pt information on requisition	LO35A		2		
16	Dry and fix separate smears, stain smears with one or more stains as directed by pathologist	LO35A		7		7
17	Coverslip and dry slides	LO35A		2		2
18	Document findings on form	LO35A		1		1
19	Under direction of the pathologist, document, label, and appropriately preserve material for additional studies and preparations (eg cytospins, cellblock, liquid based preparation, flow cytometry, cytogenetics)	LO35A		5		
20	POST-SERVICE Period					
21	Deliver specimen back to lab, decontaminateand clean cart with bleach, Unload refrigerated items, filter or change stains	LO35A		3		
22						
23	MEDICAL SUPPLIES		Unit			
24	gloves, non-sterile	SB022	pair	2		1
25	gown, impervious	SB027	item	2		
26	eye shield, non-fog	SG049	pair	2		
27	gauze squares, 4"x4", non-sterile	SG051	item	8		8
28	bleach	SL020	ml	50		
29						
30						
31	Equipment					
32	cart, laboratory	EF004		23		11
33	microscope, compound	EP024		19		11
34						
35						
36						

	A	B	C	G
2	**AMA/Specialty Society RVS Update Committee Recommendation**			**177**
3	**Meeting Date: April 2010**			**cervical or orting system), servative fluid, layer mediate tudy to uacy for separate ation episode,**
4	**LOCATION**	**CMS Code**	**Staff Type**	**Facility**
5	**GLOBAL PERIOD**			
6	**TOTAL CLINICAL LABOR TIME**	**LO35A**	**Labtech /Histo**	
7	SUBTOTAL CLINICAL LABOR PER STAFF TYPE			
8	**TOTAL PRE-SERV CLINICAL LABOR TIME PER STAFF TYPE**	**LO35A**		
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME PER STAFF**	**LO35A**		
10	**TOTAL POST-SERV CLINICAL LABOR TIME**	**LO35A**		
11	PRE SERVICE			
12	Prepare cart with markers, stains, coverslips, slides, containers, cytologic fixative and preservative solutions, requisitions, and microscope in preparation for the specimen	**LO35A**		
13	SERVICE PERIOD			
14	Prepare slides after verification of patient, label with patient identifiers. Open stain jars, gauze, folder. Unload microscope.	**LO35A**		
15	Obtain requisition, assist pathologist with documentation of pt information on requisition	**LO35A**		
16	Dry and fix separate smears, stain smears with one or more stains as directed by pathologist	**LO35A**		
17	Coverslip and dry slides	**LO35A**		
18	Document findings on form	**LO35A**		
19	Under direction of the pathologist, document, label, and appropriately preserve material for additional studies and preparations (eg cytospins, cellblock, liquid based preparation, flow cytometry, cytogenetics)	**LO35A**		
20	POST SERVICE Period			
21	Deliver specimen back to lab, decontaminateand clean cart with bleach, Unload refrigerated items, filter or change stains	**LO35A**		
22				
23	MEDICAL SUPPLIES		Unit	
24	gloves, non-sterile	SB022	pair	
25	gown, impervious	SB027	item	
26	eye shield, non-fog	SG049	pair	
27	gauze squares, 4"x4", non-sterile	SG051	item	
28	bleach	SL020	ml	
29				
30				
31	Equipment			
32	cart, laboratory	EF004		
33	microscope, compound	EP024		
34				
35				
36				

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2010

Archival Retrieval for Mutational Analysis

In October 2009, the CPT Editorial Panel created a new CPT code 88363 to account for pathologists' identification and selection of the appropriate tumor tissue in KRAS assays.

88363
The RUC reviewed the survey results for code 88363 *Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)* and agreed with the specialty society's recommendation to bundle the surveyed pre and post-service time into the intra-service time to be consistent with other Pathology codes that have recently been reviewed. The RUC agreed to a total time of 17 minutes.

445

The RUC compared the surveyed code to the reference code 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (Work RVU = 0.73 and intra time = 20 minutes). Given that the survey respondents overwhelmingly ranked the reference code's intensity and complexity measures higher than 88363 and 88334 has 3 more intra-service minutes, the RUC agreed that the surveyed code should be significantly lower than 88334.

To find appropriate relativity, the RUC compared the service to three analogous services. First, the RUC reviewed 86320 *Immunoelectrophoresis; serum* (Work RVU = 0.37 and total time = 17 minutes) and agreed that this service compared similarly to 88363 in its intensity, complexity and total time. Second, 86325 *Immunoelectrophoresis; other fluids (eg, urine, cerebrospinal fluid) with concentration* (Work RVU = 0.37, 14 minutes total time) was compared to the survey code and the RUC agreed that while this code has 3 less total minutes, it has a higher intensity and should thus be valued similarly. Finally, the RUC compared 85576 *Platelet, aggregation (in vitro), each agent* (Work RVU = 0.37, 19 minutes total time) with the surveyed code and came to a consensus that this physician work valuation is also highly comparable to the service in review. **The RUC recommends 0.37 Work RVUs for 88363.**

Practice Expense
The RUC reviewed the practice expense inputs and approved 10 minutes of total clinical time for this service. Additionally, medical supplies and equipment were edited and agreed upon for the typical patient scenario.

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

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommenda-tion
•88363	Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, *KRAS* mutational analysis)	XXX	0.37

446

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:88363 Tracking Number T1 Specialty Society Recommended RVU: **0.60**
Global Period: XXX RUC Recommended RVU: **0.37**

CPT Descriptor: Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old man had a colectomy two years ago for a colonic adenocarcinoma. The laboratory processed the surgical specimen and issued a surgical pathology report. The patient now presents with probable liver metastases, diagnosed clinically. The patient's oncologist requests that the pathologist send tissue to a reference laboratory for KRAS gene mutation analysis.

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

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

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

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work: N/A

Description of Intra-Service Work: After verifying that the patient has tissue samples in the pathology archives, the pathologist reviews the reports and examines the slides and blocks from the relevant specimens to determine which has the richest and most representative area of non-necrotic tumor for KRAS analysis, such to be sent to an appropriate reference testing laboratory. The service does not include the molecular diagnostic interpretation or microdissection. The physician (pathologist) will document the review of the pertinent pathology reports and slides and selection of the appropriate material for submission.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	Jonathan L. Myles, MD				
Specialty(s):	College of American Pathologists				
CPT Code:	88363				
Sample Size:	750	**Resp N:**	87	**Response:** 11.6 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	5.00	**10.00**	25.00	400.00
Survey RVW:	0.26	0.60	**0.73**	0.85	1.56
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	5.00	**10.00**	15.00	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: XXX Global Code

CPT Code:	88363	**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:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**17.00**		

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
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
11000	000	0.60	**RUC Time**	124,089

CPT Descriptor 1 Debridement of extensive eczematous or infected skin; up to 10% of body surface

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11056	000	0.61	**RUC Time**	1,586,212

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

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:** 24.1 **%**

TIME ESTIMATES (Median)	CPT Code: 88363	Key Reference CPT Code: 88334	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	17.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**17.00**	**20.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	1.90	2.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.05	2.14
Urgency of medical decision making	1.67	2.52
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.05	2.52
Physical effort required	1.48	1.71
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	1.62	2.52
Outcome depends on the skill and judgment of physician	2.10	2.67
Estimated risk of malpractice suit with poor outcome	1.68	2.38

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.43	1.62
Intra-Service intensity/complexity	2.05	2.33
Post-Service intensity/complexity	1.81	1.76

Additional Rationale and Comments

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

Following the survey, the data were reviewed by an Expert Panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

The Expert Panel recommends the RVW value of 0.60.

The Panel took these steps in reaching their conclusion:

1) Reviewed the survey results
2) Compared the recommended RVW, time and intensity/complexity of 88363 to the reference service 88334 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site
3) Compared other services/procedures on the MPC List to the recommended RVW and time of 88363

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 0.73 was too high since the intensity of 88363 was less than that of the reference service code. The Panel also looked at other services/procedures with the same total time as the new code, and felt the 25% survey value of 0.60 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) 88399

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

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

Estimate the number of times this service might be provided nationally in a one-year period? 20,000-25,000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Some 17,000 KRAS tests were performed in 2007. Therefore, this service will increase in the following years.

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? 10000-12500 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 50% of this service may be provided on behalf of Medicare beneficiaries.

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 85396

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

CPT Code: 88363

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

CPT Long Descriptor: Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)

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, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

Please describe in detail the clinical activities of your staff:
Pre-Service Clinical Labor Activities:

- **Pull original slides and reports on the case. (2 cases typical)**
- **Pull block selected by pathologist from archives (1 case, block)**

Intra-Service Clinical Labor Activities:

None

Post-Service Clinical Labor Activities:

- **File original slides which were pulled (2 cases typical)**
- **File original slides which were pulled (2 cases typical)**

AMA/Specialty Society RVS Update Commiteee Recommendation			88363
Meeting Date: February 2010			Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)
LOCATION	**CMS Code**	**Staff Type**	**Non-Facility**
GLOBAL PERIOD			
TOTAL CLINICAL LABOR TIME	LO33A	Labtech	10
SUBTOTAL CLINICAL LABOR PER STAFF TYPE	LO33A	Labtech	
TOTAL PRE-SERV CLINICAL LABOR TIME PER STAFF TYPE	LO33A	Labtech	6
TOTAL SERVICE PERIOD CLINICAL LABOR TIME PER STAFF	LO33A	Labtech	
TOTAL POST-SERV CLINICAL LABOR TIME	LO33A	Labtech	4
PRE-SERVICE			
Pull original slides and reports on the case. (2 cases typical)	L033A	Labtech	3
Pull block selected by pathologist from archives. (1 case, block)	L033A	Labtech	3
SERVICE PERIOD			
Other Activity (please specify)			
POST-SERVICE Period			
File original slides which were pulled (2 cases typical)	L033A	Labtech	2
File original slides which were pulled (2 cases typical)	L033A	Labtech	2
MEDICAL SUPPLIES	CMS Code	Unit	
~~Slide specimen mailer, 1-5 slides~~	~~SL121~~		
~~Federal Express Cost (average across all zones - $37.67)~~			
Federal Express Cost (average across all zones - $23.00)			1
Equipment	CMS Code		
microscope, compound	EP024		6 minutes

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2009

Immunization Administration

The CPT Editorial Panel revised the reporting of immunization administration in the pediatric population in order to better align the service with the evolving best practice model of delivering combination vaccines. This revision in the reporting of immunization administration will then permit a more accurate reflection of the physician work involved, reducing barriers to the spread of technology and allowing positive change in the practice of medicine. The CPT nomenclature needs to be kept up-to-date with the reporting of services associated with vaccine delivery, which has changed due to the licensure of additional combination vaccines as well as those with more components. The two new immunization administration codes will more accurately reflect the service as currently delivered.

The specialty society presented compelling evidence that the physician time has changed in performing these services by providing rationale for an increasing frequency of counseling necessary to convince parents to 1) immunize their children at all; and 2) to persuade them of the safety and efficacy of component vaccines. Increased attention to vaccine safety on the Internet and in other media has driven anxiety and have necessitated additional physician involvement and discussion with parents. The RUC agreed that this increased physician work should be recognized.

The specialty society presented that the typical patient receives two vaccinations in one visit. However, based upon the age of the patient and specific vaccines available, some visits require only 90460, some visits require one or more units of 90460 and one or more units of 90461. It was noted that higher multiples of reporting of these codes would occur at infrequent visits (primarily 2 month, 6 months, and 4 years of age) and any payor concern regarding coding and valuation with these outlier visits may be addressed with a limit on the number of 90461 units allowed.

90460 Immunization Administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care profession; first vaccine/toxoid component

The RUC recommends that the survey intra-service time of 7 minutes should be reflected as the total time. Pre-service time, as described in the original SOR, is described in the preventive medicine services and the post-service descriptions reflect activities performed by clinical staff. The RUC agreed that the valuation for this service falls between the range of a 99211 (Work RVU=0.17) and the survey median of 0.25, and determined that considering that more than one unit is often coded, a value of 0.20 would be appropriate. 99401 *Preventive Counseling, 15 minutes* (work RVU = 0.48) is a reasonable comparison. Using the ratio of time of 7 minutes/15 minutes, a value of 0.20 is reasonable. In addition, the committee considered that they typical patient may receive two units of this service 0.40 total with 14 minutes of counseling, which is comparable to a 99212 (work RVU = 0.48 and 16 minutes of total time). **The RUC recommends a work value of 0.20 and physician intra-service time of 7 minutes for 90460.**

90461 – Immunization Administration through 18 years of age via any route of administration, with counseling by physician or other qualified health profession; each additional vaccine/toxoid component (List separately in addition to code for primary procedure)

458

The RUC understands that additional counseling is required to describe the additional vaccines and to address concern related to media reports of component vaccines. The survey indicated that this additional counseling requires 5 minutes of physician time. The RUC determined that the survey's 25th percentile work RVU of 0.16 is appropriate and reflects a proper rank order relationship with 99401 *Preventive Counseling* as described above and also in relationship to other counseling services, such as 99407 *Smoking Cessation (5/15 or 1/3 of 0.50).* **The RUC recommends a work value of 0.16 and a physician intra-service time of 5 minutes for 90461.**

Practice Expense – The RUC recommends the direct expense inputs of18 minutes clinical staff time, supplies and equipment for 90460 and no direct inputs for 90461 The individual inputs are described in the attached handout.

PLI Crosswalk – The new codes could be crosswalked to the existing immunization and administration codes, 90471 and 90472.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Codes 90465-490460 and 90461 must be reported in addition to the vaccine and toxoid code(s) 90476-90749. Report codes 90460 and 90461 only when the physician or qualified health care professional provides face-to-face counseling of the patient and family during the administration of a vaccine. For immunization administration of any vaccine that is not accompanied by face-to-face physician or qualified health care professional counseling to the patient/family or for administration of vaccines to patients over 18 years of age, report codes 90471-90474. If a significant separately identifiable Evaluation and Management service (eg, office or other outpatient services, preventive medicine services) is performed, the appropriate E/M service code should be reported in addition to the vaccine and toxoid administration codes. A component refers to all antigens in a vaccine that prevent disease(s) caused by one organism (see codes 90460 and 90461). Combination vaccines are those vaccines that contain multiple vaccine components. (For allergy testing, see 95004 et seq) (For skin testing of bacterial, viral, fungal extracts, see 86485-86580) (90465-90468 have been deleted. To report, see 90460, 90461)				
D 90465		~~Immunization administration under 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~~ ~~(Do not report 90465 in conjunction with 90467)~~	XXX	N/A
D +90466		~~Immunization administration younger than 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; each additional injection (single or combination vaccine/toxoid), per day~~	ZZZ	N/A

459

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		~~(List separately in addition to code for primary procedure)~~ ~~(Use 90466 in conjunction with 90456 or 90467)~~		
D 90467		~~Immunization administration under 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~~ ~~(Do not report 90467 in conjunction with 90465)~~	XXX	N/A
D +90468		~~Immunization administration younger than age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; each additional administration (single or combination vaccine/toxoid), per day (List separately in addition to code for~~ ~~(Use 90468 in conjunction with 90465 or 90467)~~	ZZZ	N/A
• 90460	E1	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component	XXX	0.20
• 90461	E2	each additional vaccine/toxoid component (List separately in addition to code for primary procedure) (Use 90460 for each vaccine administered. For vaccines with multiple components [combination vaccines], report 90460 in conjunction with 90461 for each additional component in a given vaccine) (For therapeutic or diagnostic injections, see 96372-96379) (90465-90468 have been deleted. To report, see 90460, 90461)	ZZZ	0.16

460

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90460 Tracking Number E1 Specialty Society Recommended RVU: **0.25**
Global Period: XXX RUC Recommended RVU: **0.20**

CPT Descriptor: Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 15-year-old patient receives the Human Papilloma virus (HPV) vaccine from her physician. The ordering physician discusses the risks of the vaccine and the disease for which it provides protection. The parent/guardian is given the CDC vaccine information statement (VIS). The parent/guardian consents and the nurse prepares the vaccine. The patient receives the vaccine by a single injection, and the nurse charts the required information and accesses and enters the vaccine data into the statewide immunization registry. The patient is discharged home after the nurse confirms that there are no serious immediate reactions.

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

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

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

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

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

Moderate Sedation

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

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Description of Pre-Service Work:

Description of Intra-Service Work: The physician discusses the specific risks/benefits of the first vaccine component including the risks associated with this component and the risk of not receiving it to include both health risk from the preventable disease and the social concerns related to school mandates for vaccines. The physician then discusses the benefit of being immunized for this disease. The parent 's questions regarding the safety of the inactive ingredients in the vaccine such as preservatives and the likelihood of this vaccine causing injury, including brain damage, and/or the disease for which it is providing protection against are addressed. After further discussion, the parent then agrees with need for immunization. The physician then discusses the care plan for the child in the days to follow specific to the anticipated or possible side effects of the first vaccine component: soreness and pain at the injection site, fever, and other side effects. The physician reviews the signs or symptoms that warrant a call back.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2009		
Presenter(s):	Steve Krug, MD, FAAP and Margie Andreae, MD, FAAP		
Specialty(s):	American Academy of Pediatrics (AAP)		
CPT Code:	90460		
Sample Size:	786	**Resp N:** 87	**Response:** 11.0 %
Sample Type:	Panel **Additional Sample Information:** Sample drawn from membership of the AAP Section on Administration & Practice Management		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	250.00	**800.00**	1350.00	5000.00
Survey RVW:	0.15	0.25	**0.25**	0.39	0.75
Pre-Service Evaluation Time:			**3.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	5.00	**7.00**	8.00	20.00

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

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

Specialty Society Recommended Data

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

CPT Code:	90460	**Recommended Physician Work RVU: 0.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**7.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
99441	XXX	0.25	**RUC Time**

CPT Descriptor Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
36405	XXX	0.31	**RUC Time**	14

CPT Descriptor 2 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

Other Reference CPT Code	Global	Work RVU	Time Source
99406	XXX	0.24	**RUC Time**

CPT Descriptor Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

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

Number of respondents who choose Key Reference Code: 39 **% of respondents:** 44.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 90460**	**Key Reference CPT Code: 99441**	**Source of Time RUC Time**
Median Pre-Service Time	0.00	1.00	
Median Intra-Service Time	7.00	8.00	
Median Immediate Post-service Time	0.00	4.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	**7.00**	**13.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.26	2.41
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.59	2.85
Urgency of medical decision making	2.74	3.05
Technical Skill/Physical Effort (Mean)		
Technical skill required	1.49	1.51
Physical effort required	1.31	1.31
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.46	2.97
Outcome depends on the skill and judgment of physician	2.64	2.95
Estimated risk of malpractice suit with poor outcome	4.31	3.03

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	1.44	1.31
Intra-Service intensity/complexity	3.69	3.03
Post-Service intensity/complexity	1.90	1.92

Additional Rationale and Comments

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.*

The American Academy of Pediatrics (AAP) Committee on Coding and Nomenclature reviewed the 90460 survey results. Given the robustness and validity of the data, the AAP recommends the survey median work relative value units of 0.25 and the pre-, intra-, and post-service times of 3 minutes, 7 minutes, and 2 minutes, respectively.

SERVICES REPORTED WITH MULTIPLE 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) Immunizations are typically administered during the same patient encounter as a separately reported Preventive Medicine 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. A 15-year old patient receives the Human Papilloma virus (HPV) vaccine from her physician. The ordering physician discusses the risks of the vaccine and the disease for which it provides protection. The parent/guardian is given the CDC vaccine information sheet (VIS).The parent/guardian consents and the nurse prepares the vaccine. The patient receives the vaccine by a single injection, and the nurse charts the required information and accesses and enters the vaccine data into the statewide immunization registry. The patient is discharged home after the nurse confirms that there are no serious immediate reactions.
   This service is typically provided in conjunction with a separately reported Preventive Medicine Service.

	CPT Code	Descriptor	Global Period	2009 wRVUs	Pre-Time	Intra-Time	Post-Time
3.							
4.	99394	Prev med serv	XXX	1.36	5	25	5
5.	90649	HPV vaccine	N/A	N/A	N/A	N/A	N/A
6.	90460	Imm admin; first component	XXX	0.25	3	7	2

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90465-90468

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

Specialty Pediatrics How often? Commonly

pecialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 52232422

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 a birth cohort managed by pediatricians of 2,843,045 patients and adherence to the ACIP/AAP/AAFP Recommended Immunization Schedule.

Specialty Pediatrics Frequency 52232422 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,033 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Source: 2007 Medicare claims data for code 90465. NOTE: This is a pediatric service not typically provided to Medicare patients.

Specialty Pediatrics Frequency 1033 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? (ie. simil work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 90471 the exisitng immunization administration code

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:90461 Tracking Number E2 Specialty Society Recommended RVU: **0.18**
Global Period: ZZZ RUC Recommended RVU: **0.16**

CPT Descriptor: Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A four-month-old patient receives the diphtheria, tetanus, pertussis, Hemophilus influenza type b, inactivated polio (DTaP-Hib-IPV) combination vaccine from her physician. The ordering physician discusses the risks of each additional vaccine component (eg, tetanus) and the diseases for which each additional vaccine component provides protection. The parent/guardian is given the CDC vaccine information statement (VIS) for each additional vaccine component. The parent/guardian consents for each of the additional vaccine components. The nurse charts the required information and enters data into the statewide immunization registry for each additional vaccine component.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

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

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

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work: .

Description of Intra-Service Work: The physician discusses the specific risks/benefits of each additional vaccine component including the risks associated with each additional component and the risk of not receiving each one to include both health risk from the preventable disease and the social concerns related to school mandates for vaccines. The physician then discusses the benefit of being immunized for each disease and the absence of evidence for risk of brain damage associated with each additional component. The parent's questions regarding the safety and efficacy of giving multiple antigens at one time versus giving the vaccine in single components are addressed. After further discussion, the parent then agrees with need for immunization against each additional disease component. The physician then discusses the care plan for the child in the days to follow specific to the anticipated or possible side effects of each vaccine component.

Description of Post-Service Work: .

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2009		
Presenter(s):	Steve Krug, MD, FAAP and Margie Andreae, MD, FAAP		
Specialty(s):	American Academy of Pediatrics (AAP)		
CPT Code:	90461		
Sample Size:	786	**Resp N:** 78	**Response:** 9.9 %
Sample Type:	Panel **Additional Sample Information:** Sample drawn from membership of the AAP Section on Administration & Practice Management		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	312.50	**750.00**	1500.00	6000.00
Survey RVW:	0.09	0.16	**0.18**	0.25	1.77
Pre-Service Evaluation Time:			**2.50**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	2.00	**5.00**	5.00	25.00

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

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 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: ZZZ Global Code

CPT Code:	90461	**Recommended Physician Work RVU: 0.16**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**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? 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
96370	ZZZ	0.18	**RUC Time**

CPT Descriptor Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)

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

MPC CPT Code 1	Global	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
13122	ZZZ	1.44	**RUC Time**	13,490

CPT Descriptor 2 Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
96375	ZZZ	0.10	**RUC Time**

CPT Descriptor Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (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: 35 **% of respondents:** 44.8 %

TIME ESTIMATES (Median)	CPT Code: 90461	Key Reference CPT Code: 96370	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	5.00	5.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	**5.00**	**5.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.03	1.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.49	2.71
Urgency of medical decision making	2.69	2.89
Technical Skill/Physical Effort (Mean)		
Technical skill required	1.34	1.54
Physical effort required	1.26	1.29
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.60	2.80
Outcome depends on the skill and judgment of physician	2.77	2.91
Estimated risk of malpractice suit with poor outcome	4.49	2.83

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	1.20	1.37
Intra-Service intensity/complexity	3.57	2.80
Post-Service intensity/complexity	1.89	2.00

Additional Rationale and Comments

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.*

The American Academy of Pediatrics (AAP) Committee on Coding and Nomenclature reviewed the 90461 survey results. Given the robustness and validity of the data, the AAP recommends the survey median work relative value

units of 0.18 and the intra-service time of 5 minutes. The AAP recommends the 25th percentiles for the pre- and post-service work times of 1 minute each. Although 9046X2 is a "ZZZ" code (and "ZZZ" codes do not typically include pre- or post-service times), the AAP recommends pre- and post-service times of 1 minute each due to the additional pre- and post-service associated with each additional (ie, unique) vaccine component administered.

SERVICES REPORTED WITH MULTIPLE 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) Immunizations are typically administered during the same patient encounter as a separately reported Preventive Medicine 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. A four-month old patient receives the diphtheria, tetanus, pertussis, Hemophilus influenza type b, inactivated polio (DTaP-Hib-IPV) combination vaccine from her physician. The ordering physician discusses the risks of each additional vaccine component (eg, tetanus) and the diseases for which each additional vaccine component provides protection. The parent/guardian is given the CDC vaccine information sheet (VIS) for each additional vaccine component. The parent/guardian consents for each of the additional vaccine components. The nurse charts the required information and enters data into the statewide immunization registry for each additional vaccine component.

3.

4. This service is typically provided in conjunction with a separately reported Preventive Medicine Service.

5.	CPT Code	Descriptor	Global Period	2009 wRVUs	Pre-Time	Intra-Time	Post-Time
6.							
7.	99391	Prev med serv	XXX	1.02	2	20	4
8.	90698	DTaP-Hib-IPV	N/A	N/A	N/A	N/A	N/A
9.		vaccine					
10.	90460	Imm admin; first component	XXX	0.25	3	7	2
11.	90461	Imm admin; each add'l	ZZZ	0.18	2.50	5	2
12.		component					
13.	90461	Imm admin; each add'l	ZZZ	0.18	2.50	5	2
14.		component					
15.	90461	Imm admin; each add'l	ZZZ	0.18	2.50	5	2
16.		component					
17.	90461	Imm admin; each add'l	ZZZ	0.18	2.50	5	2
18.		component					

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unliste code is reviewed) 90465-90468

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

Specialty Pediatrics How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 49457611
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 a birth cohort managed by pediatricians of 2,843,045 patients and adherence to the ACIP/AAP/AAFP Recommended Immunization Schedule.

Specialty Pediatrics Frequency 49457611 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? 38 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Source: 2007 Medicare claims data for code 90466. NOTE: This is a pediatric service not typically provided to Medicare patients.

Specialty Pediatrics Frequency 38 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 90472 - existing immunization administration code

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:
Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
The American Academy of Pediatrics (AAP) Committee on Coding and Nomenclature developed the direct practice expense input recommendations for code 90460 using the February 2005 and February 2008 RUC-approved recommendations for code 90465.

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:

There is a phone call to answer questions/concerns that arise concerning vaccine component reactions that may appear within a few days of the administration

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

CPT Long Descriptor:
Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
The American Academy of Pediatrics (AAP) Committee on Coding and Nomenclature developed the direct practice expense input recommendations for code 90460 using the February 2005 and February 2008 RUC-approved recommendations for code 90465.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Clinical staff prepares patient chart with appropriate CDC vaccine information statement (VIS)

Intra-Service Clinical Labor Activities:

- **Clinical staff provides patient/parent with appropriate VIS**
- **Clinical staff follows up on physician's vaccine counseling session with patient/parent and obtains actual consent signature**
- **Clinical staff prepares vaccine, instructs the parent on proper positioning of the patient, selects and prepares the injection site, and administers the vaccine**
- **Clinical staff comforts the patient and directs the patient/parent to remain in the office after the service for about 20 minutes to watch for immediate reactions**
- **Clinical staff cleans room/equipment**
- **Clinical staff enters vaccine information into the patient medical record to include the vaccine type, lot number, site, date of administration, and date of VIS as required by federal law. A final check of the patient is done to confirm that there are no serious immediate reactions and final questions are answered.**
- **Clinical staff enters data into the state online immunization information system (registry) and maintains the vaccine refrigerator/freezer temperature log**

Post-Service Clinical Labor Activities:

There is a phone call to answer questions/concerns that arise concerning vaccine component reactions that may appear within a few days of the administration

	A	B	C	D	E	F	G
1	**AMA Specialty Society RVS Update Committee Recommendation**			**90460**		**90461**	
2	**Meeting Date: October 2009**	**CMS**	**Staff**	**Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component**		**Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**						
5	**TOTAL CLINICAL LABOR TIME**			**18.0**	**1.0**	**0.0**	**0.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**1.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**16.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**1.0**	**1.0**	**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): Clinical staff prepares patient chart with appropriate CDC vaccine information statement (VIS)**	**L037D**	**RN/LPN /MTA**	**1**			
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	**Clinical staff provides patient/parent with appropriate VIS**	**L037D**	**RN/LPN /MTA**	**1**			
21	Greet patient and provide gowning						
22	Obtain vital signs						
23	**Clinical staff follows up on physician's vaccine counseling session with patient/parent and obtains actual consent signature**	**L037D**	**RN/LPN /MTA**	**3**			
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	**Clinical staff prepares the vaccine, instructs the parent on proper positioning of the patient, selects and prepares the injection site, and administers the vaccine**	**L037D**	**RN/LPN /MTA**	**4**			
30	**Post-Service**						
31	**Clinical staff comforts the patient and directs the patient/parent to remain in the office after the service for about 20 minutes to watch for immediate reactions**						
32	**Clinical staff cleans room/equipment**	**L037D**	**RN/LPN /MTA**	**1**			
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): Clinical staff enters vaccine information into the patient medical record to include the vaccine type, lot number, site, date of administration, and date of VIS as required by federal law. A final check of the patient is done to confirm that there are no serious immediate reactions and final questions are answered.**	**L037D**	**RN/LPN /MTA**	**3**			

	A	B	C	D	E	F	G
1	**AMA Specialty Society RVS Update Committee Recommendation**			**90460**		**90461**	
2	**Meeting Date: October 2009**	**CMS**	**Staff**	**Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component**		**Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
40	**Clinical staff enters data into the state online immunization information system (registry) and maintains the vaccine refrigerator/freezer temperature log**	**L037D**	**RN/LPN /MTA**	**4**			
41	**End: Patient leaves office**						
42	**POST-SERVICE Period**						
43	**Start: Patient leaves office/facility**						
44	**There is a phone call to answer questions/concerns that arise concerning vaccine component reactions that may appear within a few days of the administration**	**L037D**	**RN/LPN /MTA**	**1**	**1**		
45	*Office visits:*						
46	*List Number and Level of Office Visits*						
47	99211 16 minutes		16				
48	99212 27 minutes		27				
49	99213 36 minutes		36				
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	Other						
53	*Total Office Visit Time*			**0**	**0**	**0**	**0**
54	Other Activity (please specify)						
55	**End: with last office visit before end of global period**						
56	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**				
57	**Gloves, non-sterile**	**SB022**	**1 pair**	**0.5**			
58							
59	**Syringe w/needle, OSHA compliant (SafetyGlide)**	**SC058**	**1 item**	**1**			
60	**Swab-pad, alcohol**	**SJ053**	**1 item**	**2**			
61	**Bandage, strip 0.75in x 3in (Bandaid)**	**SG021**	**1 item**	**1**			
62	**CDC information sheet**	**SK012**	**1 item**	**1**			
63	**Equipment**	**CMS Code**					
64	**Table, exam**	**EF023**					
65	**Refrigerator, vaccine, commercial grade, w/alarm lock**	**Row 63 of CMS spread-sheet**		**16.0**			
66	**Refrigerator, vaccine, temperature monitor w-alarm, security mounting w/sensors, NIST certificates**	**Row 41 of CMS spread-sheet**		**16.0**			

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2010

Esophageal Motility and High Resolution Esophageal Pressure Topography

In February, the CPT Editorial Panel combined two CPT codes and created one Category I and two Category III codes to describe two dimensional esophageal motility with stimulation and high resolution esophageal motility, also known as, high resolution esophageal pressure topography [HREPT]. HREPT provides comprehensive and concurrent information regarding the contractility of the upper esophageal sphincter, the esophageal body and the lower esophageal sphincter, as well as flow patterns within the esophagus in three dimensions.

91010 ***Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; 2-dimensional data***

The RUC reviewed and accepted compelling evidence from the surveying specialty society regarding the change in physician work for code 91010. When first valued during the Harvard studies the physician work was valued at 1.65 RVUs, subsequently during the RUC's first Five-Year Review in August 1995, CMS lowered the work value to 1.25 based on the incorrect assumption that an upper gastrointestinal endoscopy would be co-reported with 91010. CMS claims data for 2008 demonstrates that 91010 is reported with 43200 *Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (Work RVU = 1.59) less than one percent of the time. It was further explained that advancements in technology have had an impact on the physician work. The manometry catheters and recording systems currently available provide more comprehensive data including multiple line tracings representing pressure change verse time at several discrete esophageal loci, which has added time and complexity to the physician's assessment of the data, and the performance of the service. Esophageal manometry is now a much more comprehensive and complex study than it was years ago. **The RUC agreed that there was compelling evidence to change the work relative value associated with this service.**

The RUC reviewed the specialty society's survey results from 59 gastroenterologists who were familiar with this service. The specialty added 2 minutes of evaluation time to the pre-service time package and deleted 7 minutes from the positioning/scrub, dress, wait time to more accurately describe the physician work involved in prepping and positioning the patient on the examination table.

time= 13 minutes) and agreed that new service 91013 should be valued similarly and further substantiated that the physician work RVU of 0.21 provides proper rank order among and across specialties. **The RUC recommends a relative work value for CPT code 91013 of 0.21.**

Practice Expense: The RUC reviewed the specialty recommended direct practice expense inputs for 91010 and 91013 and made minor modifications for the typical patient service.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲91010	LL1	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; 2-dimensional data	000	1.50
D 91011		~~with mecholyl or similar stimulant~~	000	N/A
D 91012		~~with acid perfusion studies~~ ~~(91011, 91012 have been deleted. To report esophageal motility studies with stimulant or perfusion, use 91013)~~	000	N/A
+●91013	LL2	with stimulation or perfusion (eg, stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure) (Use 91013 in conjunction with 91010)	ZZZ	0.21
Category III				
●0240T		Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with 3-dimensional high resolution esophageal pressure topography (Do not report 0240T in conjunction with 91010)		N/A

480

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
+●0241T		with stimulation or perfusion (eg, stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure) (Use 0241T in conjunction with 0240T) (For esophageal motility studies with 2-dimensional data and stimulant or perfusion, use 91013)		N/A

481

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:91010 Tracking Number LL1 Specialty Society Recommended RVU: **1.50**

Global Period: 000 RUC Recommended RVU: **1.50**

CPT Descriptor: Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; 2-dimensional data

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48 year old female with complaints of frequent heartburn. She has tried a number of pharmacologic agents without relief of symptoms. Esophagogastroduodenoscopy (EGD) was unremarkable. She is referred for evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 71%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 10%

Is moderate 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 patient history, including prior studies.
- Explain procedure and its purpose to the patient .
- Counsel patient regarding swallowing during the test.
- Answer patient questions and obtain informed consent.
- Verify that all necessary instruments and supplies are readily available , calibrated and operational.
- Supervise patient positioning and prepping

Description of Intra-Service Work:

- The patient is positioned on the examination table and properly gowned. A swallow transducer is affixed to t neck with tape. The nares are inspected to determine which is most suitable for catheter insertion.
- Topical anesthesia is administered to the nares. Under physician supervision, the esophageal pressure probe is passed trans-nasally into the esophagus to a depth of 60cm. Pressures are checked and the probe is positioned straddling the distal esophagus / proximal stomach based on interpretation of the measurements. After positioning is confirmed, the

patient is instructed to perform 10 swallows of 5 ml liquid (typically water or saline) at not less than 30 second intervals. Pressure measurements are taken as the material moves through the esophagus into the stomach and the adequacy of the measurements is assessed. The probe is withdrawn to the correct position in the esophageal body based on interpretation of the measurements, and additional pressure measurements are taken. At the conclusion of the procedure, the probe is withdrawn.

Description of Post-Service Work: Post procedure vital signs are assessed, the patient is monitored for any complications, and the patient is then discharged from the laboratory. Report and outcome letter is dictated for referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Drs. Nicholas Nickl; Edward Bentley				
Specialty(s):	Gastroenterology				
CPT Code:	91010				
Sample Size:	178	**Resp N:**	59	**Response:** 33.1 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	15.50	**100.00**	200.00	700.00
Survey RVW:	0.35	1.50	**1.90**	2.06	4.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	0.00	15.00	**20.00**	30.00	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: 1a-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	91010	**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:		**15.00**	**13.00**	**2.00**
Pre-Service Positioning Time:		**0.00**	**1.00**	**-1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**6.00**	**-6.00**
Intra-Service Time:		**20.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
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
91122	000	1.77	**RUC Time**

CPT Descriptor Anorectal manometry

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11755	000	1.31	**RUC Time**	25,211

CPT Descriptor 1 Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
70496	XXX	1.75	**RUC Time**	99,112

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
5303	000	1.50	**RUC Time**

CPT Descriptor Proctosigmoidoscopy, rigid; with dilation (eg, balloon, guide wire, bougie)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 40.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 91010**	**Key Reference CPT Code: 91122**	**Source of Time RUC Time**
Median Pre-Service Time	15.00	20.00	
Median Intra-Service Time	20.00	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	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**50.00**	**65.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.04	3.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.96	3.83
Urgency of medical decision making	3.17	2.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.21	3.92
Physical effort required	3.00	2.88
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.88	2.63
Outcome depends on the skill and judgment of physician	4.04	3.79
Estimated risk of malpractice suit with poor outcome	2.96	2.58

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.17	3.17
Intra-Service intensity/complexity	3.50	3.42
Post-Service intensity/complexity	3.42	3.33

Additional Rationale and Comments

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

This procedure is currently Harvard valued. The societies presented a proposal to the CPT Editorial Panel in February 2010 to combine codes 91011 *(Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study; with mecholyl or similar stimulant)* and 91012 *(Esophageal motility*

(manometric study of the esophagus and/or gastroesophageal junction) study; with acid perfusion studies) into an add-on code to be reported with code 91010. Code 91010 *(Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study)* has never been surveyed by the RUC.

The presenting societies believe there is compelling evidence for a change in the physician work valuation of code 91010. We believe that an assumption of overlapping work based on endoscopy commonly performed on the same day as esophageal manometry for placement of the catheter is incorrect. Claims data show that code 91010 (reported 15,710 times to Medicare) was reported with any upper GI endoscopy procedure (codes 43200-43259) only 52 times in 2008. As the sedation agents (benzodiazepines, opioids) used for endoscopy can impact the measurement of motility, performance of upper endoscopy and an esophageal motility study on the same date of service could lead to an incorrect esophageal motility study, potentially leading to an inappropriate assumption with regards to patient management.

Second, advancements in technology that have occurred since code 91010 was reviewed have had an impact on physician work. The manometry catheters and recording systems currently available provide more comprehensive data including multiple line tracings representing pressure change versus time at several discrete esophageal loci, which has added time and complexity to the physician's assessment of the data, and the performance of the service.

A survey of the code was performed with 59 respondents of 178 surveyed (33.15%). Forty-two (71.19%) found the vignette typical, and the median performance rate was 100. There was also good clustering of most responses around the medians; these suggest a valid sample was obtained for the survey. A minority of respondents (6) indicated that moderate sedation was typical in the hospital / ASC setting. In reviewing the procedure with an expert panel, it was established that sedation is not typical.

The median wRVU by the respondents was 1.90 with times of 20/20/15. An expert panel was convened by the society, which felt that the median wRVU and pre-service times were too high. The panel recommended that fteen (15) minutes pre-service time was more appropriate as it was equal to other GI motility codes that had recently been valued by the RUC, code 91038 {Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)} and code 91022 {Duodenal motility (manometric) study}.

The median intra service time of 20 minutes and post service time of 15 minutes were considered appropriate. When compared with the key reference code 91122 wRVU 1.77 (20/30/15), 91010 is considered more complex in 10 of 11 measures. Therefore, the valuation of wRVU 1.50 appropriately reflects the increased intensity and shorter time of 91010 relative to 91122.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 91010 Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study

How often do physicians 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? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 30000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

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? 15,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. AMA RUC database

Specialty Gastroenterology Frequency 11300 Percentage 75.33 %

Specialty Surgery Frequency 1800 Percentage 12.00 %

Specialty Otolaryngology Frequency 360 Percentage 2.40 %

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

---

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) 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

TAB 20

Compelling Evidence Argument CPT 91010

Regarding "compelling evidence" for re-valuation of this code, we recommend that the existing RUC compelling evidence standard is met in two respects. First, the existing valuation of the code has assumed that endoscopy was commonly performed on the same day as esophageal manometry for placement of the catheter. The RUC rationale from August 1995 states;

> *RUC Recommendation – 1.25 RVW*
>
> *These codes were identified as potentially overvalued by the CMDs. The CMDs noted that the work and intensity of 91010, 91011, 91012, 91020, and 91030 is not as great as CPT code 99204 [Office visit of moderate complexity]. The physician is allowed to code esophagoscopy (43200) with 91010, 91011, 91012, 91020, and 91030 if the esophageal pressure measuring device is placed during esophagoscopy. The interpretation of esophageal motility (91010, 91011, 91012), esophageal manometry (91020), and acid perfusion (91030), should be no more work than 78262 [gastroesophageal reflux study]. The RUC agreed to accept the proposed reduction of RVUs for these codes.*
>
> *There was no request by the specialty to survey this procedure. Therefore, the RUC agreed to accept the proposed reduction of RVUs for these codes.*
>
> *-From the Other Medical and Therapeutic section*

Based on this rationale, the original Harvard valuation of 1.65 wRVUs was reduced to the current 1.25 wRVUs. At this time endoscopy is only rarely co-reported with manometry. Claims data from 2008 demonstrate that 91010 was co-reported with any upper GI endoscopy code only 52 times of 15,407 reported procedures. Therefore the earlier assumption of overlapping work based on co-reporting of 91010 with upper GI endoscopy is an assumption which no longer prevails (Compelling evidence standard: "Evidence that incorrect assumptions were made in the previous valuation of the service").

Second, advancements in technology that have occurred since code 91010 was reviewed that have had an impact on physician work. The manometry catheters and recording systems currently available provide more comprehensive data including multiple line tracings representing pressure change versus time at several discrete esophageal loci, which has added time and complexity to the physician's assessment of the data, and the performance of the service. The catheters enable the physician to assess the impact of baseline and respiratory variation in intragastric pressure on pressure loci in the distal esophagus and at the esophago-gastric junction. Increasing the number of pressure sensors on the manometric assembly and reducing the proximity between the pressure sensors results in additional data that must be addressed by the physician. The survey data to be presented to the RUC reflects the increased time to perform the service which we believe is best explained by changes in the motility catheter and recording systems compared to previous Harvard valuation.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:91013 Tracking Number LL2 Specialty Society Recommended RVU: **0.21**

Global Period: ZZZ RUC Recommended RVU: **0.21**

CPT Descriptor: Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report;with stimulation or perfusion (eg, stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure)
(Report 91013 in conjunction with 91010)
(Do not report 91013 more than once per session)
(Codes 91011, 91012 have been deleted. To report esophageal motility studies with stimulant or perfusion, use 9101X1)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 49 year old female with complaints of heartburn and chest pain. Cardiac evaluation and esophagogastroduodenoscopy (EGD) were unremarkable. She has tried a number of pharmacologic agents without relief of symptoms. She is referred for evaluation of esophageal function to assess symptoms in response to stimulation agents.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 8%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 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: N/A

Description of Intra-Service Work:

- After a baseline esophageal motility study is performed, topical anesthesia is administered to the nares and a second small infusion catheter is placed through the contra-lateral nares into the esophagus to a distance of 30-35cm from the nares. The motility probe is re-positioned to straddle the distal esophagus, checking pressure measurements. The stimulant is infused through the infusion catheter. The patient is asked to perform a further series of swallows, an additional esophageal pressure measurements are taken. At the conclusion of this part of the procedure, the infusion catheter is removed. The recording is saved for subsequent interpretation.
- Physician interpretation of the tracings includes the additional measurements obtained following administration of the provocative agent.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Nicholas Nickl; Edward Bentley				
Specialty(s):	Gastroenterology				
CPT Code:	91013				
Sample Size:	179	**Resp N:**	36	**Response:** 20.1 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**3.00**	20.00	300.00
Survey RVW:	0.10	0.25	**1.00**	1.46	2.70
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	13.75	**22.50**	30.00	60.00

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

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1a-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	91013	**Recommended Physician Work RVU: 0.21**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**13.00**	**-13.00**
Pre-Service Positioning Time:		**0.00**	**1.00**	**-1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**6.00**	**-6.00**
Intra-Service Time:		**14.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
43760	000	0.90	**RUC Time**

CPT Descriptor Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11719	XXX	0.17	**RUC Time**	1,453,567

CPT Descriptor 1 Trimming of nondystrophic nails, any number

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.22	**RUC Time**	14,267,661

CPT Descriptor 2 Radiologic examination, chest, 2 views, frontal and lateral

Other Reference CPT Code	Global	Work RVU	Time Source
96411	XXX	0.20	**RUC Time**

CPT Descriptor Chemotherapy administration; intravenous, push technique, each additional substance/drug (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: 15 **% of respondents:** 41.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 91013**	**Key Reference CPT Code: 43760**	**Source of Time RUC Time**
Median Pre-Service Time	0.00	17.00	
Median Intra-Service Time	14.00	10.00	
Median Immediate Post-service Time	0.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
edian Office Visit Time	0.0	0.00	
rolonged Services Time	0.0	0.00	
Median Total Time	**14.00**	**32.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.07	3.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.20	3.27
Urgency of medical decision making	3.20	2.73
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.13	3.47
Physical effort required	3.40	3.67
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.40	3.47
Outcome depends on the skill and judgment of physician	4.13	3.73
Estimated risk of malpractice suit with poor outcome	3.20	3.73

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.47	3.20
Intra-Service intensity/complexity	4.27	3.33
Post-Service intensity/complexity	3.47	3.20

Additional Rationale and Comments

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

This procedure has previously been reported with code 91011, *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study; with mecholyl or similar stimulant* wRVU 1.50, or code 91012, *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study; with acid perfusion studies* wRVU 1.46, which are 000 day global

codes which include the base esophageal manometry study, 91010 *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study.*

The new code 9101X1 is an add-on ZZZ code, which would be reported with code 91010. Both 91011 and 91012 are rarely eported, with 123 and 206 Medicare claims filed in 2008 (respectively). The incremental increase in value of 91011 and 91012 rom the base code 91010 is respectively, 0.25 and 0.21 wRVU or 0.46 wRVU combined. The new code encompasses the additional work resulting from the placement of a second intra-nasal catheter and intra-esophageal stimulating agent, obtaining additional esophageal pressure measurements and interpretation of additional waveform tracings.

There were 36 responses (sample size 179, response rate 20.1%) with a median survey response wRVU of 1.00 with times of 15/22.5/10. These data suggest that many or most survey respondents did not understand the add-on nature of this code and included work of the base manometry in their work estimates. This view is supported by their selection of 43760 as the Key Reference Service, *Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance*, wRVU 0.90.

The expert panel felt that there should be no additional pre-time or post service time and that would have been captured in the base code 91010. The expert panel recommended that this service represents more intra-service work than code 96374, Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug, wRVU 0.18, as the patient required placement of a second intra-nares catheter for infusion of the stimulation agent. The panel felt that this service was not as involved as code 91037, Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation, wRVU 0.97. The expert panel felt that the survey 25th percentile represented more appropriate times and work as adjusted (wRVU 0.25 0/14/5). However, the societies are recommending that the code be valued at the equivalent of the acid perfusion study increment of 0.21 wRVU and 0/14/0, since this is the more commonly performed test. The incremental procedure work has not changed since its original valuation. Therefore, at this time the established "compelling evidence" criteria to indicate potential mis-valuation of the code are not met.

The recommended valuation is less than MPC code 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* wRVU 0.48 2/10/4 global XXX and slightly higher than code 71020 *Radiologic examination, chest, 2 views, frontal and lateral* wRVU 0.22 1/3/1 global XXX. In addition, code 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug* wRVU 0.28 3/4/3 XXX global also upports the valuation recommended by the surveying societies.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

	cpt code	global	pre	intra	post	work rvu
3.	91010	000	15	20	15	1.50

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 91011; 91012

How often do physicians 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? 700
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 350
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty 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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 11201, ZZZ global, similar value, similar intensity

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

	A	B	C	D	E
1	**AMA/Specialty Society RVS Update Committee**			**91010**	
2	**Meeting Date: April / May RUC**	**CMS**	**Staff**	**Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study; REVISED**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**000**	
5	**TOTAL CLINICAL LABOR TIME**			**75.0**	**19.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**9.0**	**19.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**63.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**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			**3**	**3**
12	Coordinate pre-surgery services			**0**	**3**
13	Schedule space and equipment in facility			**0**	**5**
14	Provide pre-service education/obtain consent			**3**	**5**
15	Follow-up phone calls & prescriptions			**3**	**3**
16	Other Clinical Activity (please specify)				
17		L037D	RN/LPN/MTA		
18	**End: When patient enters office/facility for surgery/procedure**				
19	**SERVICE PERIOD**				
20	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**				
21	Review charts				
22	Greet patient and provide gowning	L037D	RN/LPN/MTA	**3**	
23	Obtain vital signs	L037D	RN/LPN/MTA	**3**	
24	Provide pre-service education/obtain consent				
25	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	**2**	
26	Setup scope (non facility setting only)				
27	Prepare and position patient/ monitor patient/ set up IV				
28	Sedate/apply anesthesia				
29	**Intra-service**				
30	Perform procedure	L037D	RN/LPN/MTA	**35**	
31	**Post-Service**				
32	Monitor pt following service/check tubes, monitors, drains			**3**	
33	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	**3**	
34	Clean Scope				
35	Clean Manometry equipment	L037D	RN/LPN/MTA	**7**	
36	Complete diagnostic forms, lab & X-ray requisitions			**3**	
37	Review/read X-ray, lab, and pathology reports			**2**	
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			**2**	
39	Discharge day management	L037D	RN/LPN/MTA		
40	Other Clinical Activity (please specify)				
41		L037D	RN/LPN/MTA	**0**	
42	**End: Patient leaves office**				
43	**POST SERVICE Period**				
44	**Start: Patient leaves office/facility**				
45	Conduct phone calls/call in prescriptions			**3**	
46	*Office visits*				
47	*List Number and Level of Office Visits*				
48	99211 16 minutes		16		
49	99212 27 minutes		27		
50	99213 36 minutes		36		
51	99214 53 minutes		53		
52	99215 63 minutes		63		
53	Other				
54	*Total Office Visit Time*				
55	Other Activity (please specify)				
56		L037D	RN/LPN/MTA		
57	**End: with last office visit before end of global period**				
58	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**		
59	basin, emesis	SJ010	item	1	
60	canister, suction	SD009	item	1	
61	cap, surgical	SB001	item	2	
62	computer media, floppy disk 1 44mb	SK014	item	1	
63	denture cup	SJ016	item	1	
64	drape, non-sterile, sheet 40in x 60in	SB006	item	2	
65	drinking straw	SK020	item	1	
66	gauze, sterile 4in x 4in	SG055	item		

	A	B	C	D	E
1	**AMA/Specialty Society RVS Update Committee**			**91010**	
2	**Meeting Date: April / May RUC**	**CMS**	**Staff**	**Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study; REVISED**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
67	gauze, non-sterile 4in x 4in	SG051	item	5	
68	gown, staff, impervious	SB027	item	2	
69	lidocaine 1%-2% inj (Xylocaine)	SH047	ml		
70	lidocaine 2% jelly, topical (Xylocaine)	SH048	ml	20	
71	lubricating jelly (K-Y) (5gm uou)	SJ032	item	4	
72	mask, surgical, with face shield	SB034	item	2	
73	pack, minimum multi-specialty visit	SA048	pack	1	
74	paper, recording (per sheet)	SK059	item		
75	paper, laser printing (each sheet)	SK057	item	3	
76	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1	
77	tape, surgical paper 1in (Micropore)	SG079	inch	12	
78	tongue depressor	SJ061	item	1	
79	biohazard bag	SM004	item	1	
80	disinfectant spray (Transeptic) ml	SM012	item	5	
81	transducer dome (pressure)	SD125	item		
82	tubing, suction, non-latex (6ft uou)	SD132	item		
83	tubing, suction, non-latex (6ft) with Yankauer tip (1)	SD134	item	1	
84	enzymatic detergent	SM015	oz	1	
85	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz	6	
86	basin, irrigation	SJ009	item	2	
87	**Equipment**	**CMS Code**			
88	light, surgical	EF014		63	
89	manometry catheter, reusable	(blank)		50	
90	manometry accessory cable	(blank)		50	
91	manometry system (computer, transducers, catheter)	EQ181		50	
92	suction machine (Gomco)	EQ235		56	
93	Mayo stand	EF015		63	
94	table, exam	EF023		63	

	A	B	C	D	E
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**+91013**	
2	**Meeting Date: April / May RUC**	**CMS**	**Staff**	**Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study;**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**ZZZ**	
5	**TOTAL CLINICAL LABOR TIME**			**9.0**	**0.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**9.0**	**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		L037D	RN/LPN/MTA		
18	**End: When patient enters office/facility for surgery/procedure**				
19	**SERVICE PERIOD**				
20	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**				
21	Review charts				
22	Greet patient and provide gowning				
23	Obtain vital signs				
24	Provide pre-service education/obtain consent				
25	Prepare room, equipment, supplies				
26	Setup scope (non facility setting only)				
27	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	**2**	
28	Sedate/apply anesthesia				
29	**Intra-service**				
30	Assist physician in performing procedure	L037D	RN/LPN/MTA	**7**	
31	**Post-Service**				
32	Monitor pt. following service/check tubes, monitors, drains				
33	Clean room/equipment by physician staff				
34	Clean Scope				
35	Clean Surgical Instrument Package				
36	Complete diagnostic forms, lab & X-ray requisitions				
37	Review/read X-ray, lab, and pathology reports				
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
39	Discharge day management				
40	Other Clinical Activity (please specify)				
41		L037D	RN/LPN/MTA		
42	**End: Patient leaves office**				
43	**POST-SERVICE Period**				
44	**Start: Patient leaves office/facility**				
45	Conduct phone calls/call in prescriptions				
46	*Office visits:*				
47	*List Number and Level of Office Visits*				
48	99211 16 minutes		16		
49	99212 27 minutes		27		
50	99213 36 minutes		36		
51	99214 53 minutes		53		
52	99215 63 minutes		63		
53	Other				
54	*Total Office Visit Time*				
55	Other Activity (please specify)				
56		L037D	RN/LPN/MTA		
57	**End: with last office visit before end of global period**				
58	**MEDICAL SUPPLIES**		**Unit**		
59	catheter, red rubber	SD029	item	1	
60	sodium chloride 0 9% irrigation (500-1000ml uou)	SH069	item	1	
61	stop cock, 3-way	SC049	item	1	
62	HCl, 1% hydrochloric acid	SL229	cc	10	
63	**Equipment**				
64	light, surgical	EF014		9	
65	manometry catheter, reusable	(blank)		9	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2010

Colon Motility

In February 2010, the CPT Editorial Panel created a new CPT code for the assessment of colon muscle function. Analysis of the peristalsis and tone is important in the evaluation of complex and clinically poorly responsive colonic dysfunction, pseudo-obstruction, and severe symptomatic constipation and diarrhea in pediatric and adult populations. This new study accurately describes the assessment of the muscle function, peristalsis, and the tone of the entire colon.

91117 ***Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report***

505

The RUC reviewed the survey results from 33 gastroenterologists for CPT code 91117. Although the RUC concurred that the survey results were strong, they agreed with the specialty that the respondents reported duplicative time in the pre-service and post service periods related to separately reported fluoroscopic or endoscopic procedures. The RUC agreed with the specialty recommendation to eliminate this duplication in time by reducing the total pre-service time from 35 to 15 minutes and reducing the immediate post time from 60 minutes to 30 minutes. By reducing these physician time components the recommended physician time for CPT code 91117 accurately reflects the typical service being performed (15 minutes pre-service. 60 minute intra-service, and 30 minutes post-service)

The RUC compared the physician work, time, intensity, and complexity with the survey's Key Reference service, 91022 *Duodenal motility (manometric) study* (Work RVU = 1.44, 15 minutes pre, 60 minutes intra-service, and 16 minutes immediate post), 91122 *Anorectal manometry* (Work RVU = 1.77, 20 minutes pre, 60 minutes intra-service, and 15 minutes immediate post), and 99222 *Initial hospital care, per day, ...*(Work RVU 2.61, 15 minutes pre, 40 minutes intra-service, and 20 minutes immediate post) in relation to 91117. The RUC agreed that the overall physician work for 91117 was greater in intensity and complexity than 91022 and 91122. However in comparison to 99222 the RUC concurred that 91117 was slightly less intense and complex. Given these comparisons, the RUC agreed that the specialty's 25th percentile, 2.45 work RVUs, most appropriately places these services in proper rank order, as it is less than the work value for 99222, and greater than the work value for 91022 and 91122. **The RUC recommends a relative work value of 2.45 for CPT code 91117.**

New Technology: The RUC recommends that CPT code 91117 be placed on the new technology list.

Practice Expense: The RUC recommends direct practice expense inputs in the facility only as they are only performed in the facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●91117	MM1	Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report (For wireless capsule pressure measurements, use 0242T) (Do not report 91117 in conjunction with 91120, 91122)	000	2.45
91120		Rectal sensation, tone, and compliance test (ie, response to graded balloon distention)	XXX	0.97 (No Change)
91122		Anorectal manometry (Do not report 91120, 91122 in conjunction with 91117)	000	1.77 (No Change)

506

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:91117 Tracking Number MM1 Specialty Society Recommended RVU: **2.45**

Global Period: 000 RUC Recommended RVU: **2.45**

CPT Descriptor: Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report

(For wireless pressure measurements, see 00X6T)
(Do not report 91117 in conjunction with 91120 or 91122)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 13-year old girl presents with a multi-year history of chronic abdominal pain, constipation and recurrent fecal impactions that has not responded to medical therapy. Previous radiology, endoscopy and motility diagnostic studies have been unremarkable.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 33%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

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

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Description of Pre-Service Work:

- The patient history and procedure indications are reviewed including contraindications to planned provocative testing.
- The procedure, risks, and benefits are discussed with the patient and/or family member(s) and informed consent is obtained.

Description of Intra-Service Work:

After placement of the colon motility catheter in a prior procedure, the patient is taken to the gastrointestinal motility laboratory. The catheter assembly is connected to the computerized data collection system and initial waveforms are assessed for adequacy. If necessary, radiographic confirmation of appropriate catheter position is obtained.

- Recordings of the intraluminal tone and pressure activity of the colon are performed, utilizing a protocol of repeated testing, provocation and evaluation under physician supervision. Initially, fasting and basal colon motor activity is

assessed. The patient then receives a standardized meal and postprandial colonic tone and motility are recorded. The patient then undergoes one or more provocative challenges. Provocative challenges may include balloon distention of the colon; pharmacologic stimulation with an intraluminal agent such as biscodyl; and pharmacologic stimulation with an intravenouos agent such as neostygmine. These challenges are administered by the physician who then monitors the patient for symptom response and side effects, and also monitors the colonic manometry tracings for adequacy and effect.

- Periodically throughout the study, and always before administration of provocative tests, the physician monitors the patient's clinical status and the waveforms to assess tracing adequacy and suitability for provocative tests. If necessary, additional radiographic images are obtained and interpreted to assess catheter placement.
- The total testing period is at least 6 hours and may be up to 24 hours depending on clinically indicated testing requirements.
- At the conclusion of the study, the colon motility catheter is removed by the physician.
- The physician reviews and interprets the tracings and generates a report.

Description of Post-Service Work:

- Discharge instructions as well as preliminary findings, when available, are discussed with the patient and/or family member(s).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Drs. Nicholas Nickl; Edward Bentley				
Specialty(s):	Gastroenterology				
CPT Code:	91117				
Sample Size:	68	**Resp N:**	33	**Response:** 48.5 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**15.00**	45.00	75.00
Survey RVW:	1.44	2.45	**3.50**	4.00	10.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	25.00	60.00	**60.00**	300.00	480.00

Immediate Post Service-Time:	**60.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1a-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	91117	**Recommended Physician Work RVU: 2.45**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**13.00**	**2.00**
Pre-Service Positioning Time:		**0.00**	**1.00**	**-1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**6.00**	**-6.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
91022	000	1.44	**RUC Time**

CPT Descriptor Duodenal motility (manometric) study

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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	2.61	**RUC Time**	2,996,339

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. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
43235	000	2.39	**RUC Time**	423,238

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
31623	000	2.88	**RUC Time**

CPT Descriptor Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 45.4 **%**

TIME ESTIMATES (Median)	**CPT Code: 91117**	**Key Reference CPT Code:** 91022	**Source of Time** RUC Time
Median Pre-Service Time	15.00	15.00	
Median Intra-Service Time	60.00	30.00	
Median Immediate Post-service Time	30.00	16.00	
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	**105.00**	**61.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.27	4.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.53	4.40
Urgency of medical decision making	3.07	3.07
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.80	4.47
Physical effort required	4.33	4.13
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.73	3.47
Outcome depends on the skill and judgment of physician	4.67	4.53
Estimated risk of malpractice suit with poor outcome	3.53	3.27

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.13	3.07
Intra-Service intensity/complexity	4.67	4.13
Post-Service intensity/complexity	3.93	3.73

Additional Rationale and Comments

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

This code represents an existing technology which has previously been reported with code 91299, *unlisted diagnostic gastroenterology procedure.* This service is primarily performed in the pediatric population and in adults with debilitating constipation as a scheduled procedure. The placement of the manometry catheter is captured in a previous and separately reported colonoscopic or radiographic procedure.

A survey of the code was completed with 33 respondents of 68 surveyed (48.5%). Twenty-six (78%) found the vignette typical, and the median performance rate was 15. There was also good clustering of most responses around the medians; these suggest a valid sample was obtained for the survey. Ten (33%) of respondents indicated that moderate sedation was typical in the hospital / ASC setting. To clarify whether the sedation referred to was part of the manometry service being surveyed or was associated with the preceding colonoscopy service separately reported, an expert panel was convened. The panel confirmed that sedation is not typical for the service being surveyed, namely the performance of the motility study.

The respondents reported median pre-service evaluation, positioning, and scrub/dress/wait times of 15, 10, and 10 minutes respectively. The expert panel felt that some of this pre-service time reflected overlap with the fluoroscopic or endoscopic procedure. The panel also noted that relocating the patient from the endoscopy or fluoroscopy suite to the motility lab, and connection of the catheter array to the computer system, would add further positioning and scrub/dress/wait time. The expert panel recommended the pre-service time should be adjusted to 15 minutes, which crosswalks to the same pre-time as code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)* and code 91022, *Duodenal motility (manometric) study.*

The median intra-service time of 60 minutes represents the fraction of the total 6-24 hour study period during which the physician is at the bedside monitoring the patient's status, administering the provocative tests and observing response, and evaluating the adequacy of the tracings in real time. The median and 25th percentile post-service time reported was 60 minutes, which includes both the immediate discharge of the patient and the subsequent interpretation of the data with generation of a report. The panel concurred with a recommendation of 60 minutes of intra-service time.

The panel raised a concern with the post-service time recommended for 91117, and felt that 60 minutes of post-service time was excessive, noting that the Key Reference Service, 91022, *Duodenal motility (manometric) study*, contains 15 minutes of post-service time. The panel compared the complexity of the post-service analysis to codes 91034, *Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation* and 91035, *Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation* which have 16 minutes of post-service time, and code 91038, *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours* which has 26 minutes of post-procedure time for interpretation and reporting. The panel noted that 91117 is more complex because it contains 6-8 waveform channels and because there are no computer-interpretation algorithms for these waveform channels; thus all interpretation must be performed by the physician. The panel recommended 30 minutes for post-procedure analysis.

The Median Survey wRVU was 3.50 with 35/60/60. Using a building block methodology, if 20 minutes pre-service and 30 minutes post service time is subtracted (15 min x .0224=.33 wRVU; 5 min x .0081=.04; 30 min x .0224=0.67) the total subtracted is 1.04 wRVUs. This would result in wRVU of 2.46 (3.50-1.04) with 15/60/30 minutes of time. The expert panel recommends that the wRVU match the survey 25th percentile at 2.45 wRVU.

MPC comparison codes, 90801 *Psychiatric diagnostic interview examination* 60 minutes intra-service time and 125 minutes total time wRVU 2.80 is comparable in time and intensity. Code 43239 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple* wRVU 2.87, 27/34/24, and code 31623 B*ronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings* wRVU 2.88, 20/30/20, are similarly valued with significantly less intra service and total times. Code 93642 *Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillat (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters),* 30/60/30, wRVU 4.88 has similar times with significantly higher 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) N/A

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

Specialty 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? 1200
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 960 Percentage 80.00 %

Specialty General Surgery Frequency 120 Percentage 10.00 %

Specialty Colon and Rectal Surgery Frequency 120 Percentage 10.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 360
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Gastroenterology Frequency 288 Percentage 80.00 %

Specialty General Surgery Frequency 36 Percentage 10.00 %

Specialty Colon and Rectal Surgery Frequency 36 Percentage 10.00 %

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 43235

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

CPT Code:_91117___

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

CPT Long Descriptor:

Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report

(For wireless pressure measurements, see 00X6T)
(Do not report 91117 in conjunction with 91120 or 91122)

Global Period: 000

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

Representatives from the American Gastroenterological Association's Practice Management and Economics Committee and the American Society for Gastrointestinal Endoscopy's Practice Management Committee, other members of our societies who have expertise in coding, coverage and payment issues, and ad hoc members who have expertise with this procedure, comprise the "Gastroenterology Specialty Societies RBRVS and Practice Expense Committee". This committee met by conference call to discuss and develop our PE recommendations for this code.

The recommendations were developed through a combination of survey data review and recommendations from an expert panel highly familiar with the procedure.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Pre-service diagnostic and referral forms are completed.
- Services are coordinated to schedule the procedures with the patient and family.
- Space and equipment including special testing requirements are scheduled.
- Colon cleansing prep prescriptions are provided; administration instructions and other teaching information regarding the colon prep are provided to the patient and family
- Instructions and pre-procedure education are provided to the patient and family
- Follow up instructions and appointments are provided and scheduled.

Intra-Service Clinical Labor Activities:

None

Post-Service Clinical Labor Activities:

None

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

CPT Long Descriptor:

Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report

(For wireless pressure measurements, see 00X6T)
(Do not report 91117 in conjunction with 91120 or 91122)

Global Period: 000

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

Representatives from the American Gastroenterological Association's Practice Management and Economics Committee and the American Society for Gastrointestinal Endoscopy's Practice Management Committee, other members of our societies who have expertise in coding, coverage and payment issues, and ad hoc members who have expertise with this procedure, comprise the "Gastroenterology Specialty Societies RBRVS and Practice Expense Committee". This committee met by conference call to discuss and develop our PE recommendations for this code.

The recommendations were developed through a combination of survey data review and recommendations from an expert panel highly familiar with the procedure.

The RUC and Specialty Society recommends a no direct practice expense inputs in the non-facility setting for 9112X1.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

	A	B	C	D	E
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**91117**	
2	**Meeting Date: April / May RUC**	**CMS**	**Staff**	**Colon motility (manometric) study**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**				
5	**TOTAL CLINICAL LABOR TIME**			**0.0**	**19.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**19.0**
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	L037D	RN/LPN/MTA	0	**3**
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA	0	**3**
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0	**5**
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0	5
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	0	3
16	Other Clinical Activity (please specify)				
17		L037D	RN/LPN/MTA		
18	**End: When patient enters office/facility for surgery/procedure**				
19	**SERVICE PERIOD**				
20	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**				
21	Greet Patient and Provide Gowning, Ensure Appropriate Medical Records Are Available				
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)				
40		L037D	RN/LPN/MTA	**0**	**0**
41	**End: Patient leaves office**				
42	**POST-SERVICE Period**				
43	**Start: Patient leaves office/facility**				
44	Conduct phone calls/call in prescriptions				
45	*Office visits:*				
46	*List Number and Level of Office Visits*				
47	99211 16 minutes		16		
48	99212 27 minutes		27		
49	99213 36 minutes		36		
50	99214 53 minutes		53		
51	99215 63 minutes		63		
52	Other				
53	*Total Office Visit Time*				
54	Other Activity (please specify)				
55	**End: with last office visit before end of global period**				
56	**MEDICAL SUPPLIES**		**Unit**	none	
57	**Equipment**			none	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2010

Anterior Segment Imaging

In February 2010, the CPT Editorial Panel deleted a Category III code and created a Category I code to describe anterior segment imaging with optical coherence tomography. This medical diagnostic imaging technology allows for the high resolution cross-sectional or tomographic imaging in biologic tissues, typically for evaluating narrow angle glaucoma patients.

92132 ***Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral.***
The RUC reviewed the survey results from 30 ophthalmologists and optometrists for new code 92132 and agreed with the physician time components of 3 minutes pre-service and 10 minutes intra-service work. The RUC also noted that this service is typically billed with an evaluation and management service on the same date of service, but agreed that the service should have 3 minutes of pre-service time to accurately reflect the physician work involved to prepare the machine, examine the patient to ensure ability to fixate the eye and describe the test to the patient and to bring the pre-service time components closer in line with the survey respondents' estimation of the pre-service physician time. The RUC compared the surveyed services to the Key Reference Service 76513 *Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution* biomicroscopy (Work RVU= 0.66, total time= 19 minutes) and agreed that the reference code has greater total time and intensity as compared to the surveyed code. In addition,92132 was compared to 92025 *Computerized corneal topography, unilateral or bilateral, with interpretation and report* (Work RVU = 0.35, intra-service time = 12) and agreed that this service is similar in physician work, time, and intensity to this new service. The RUC agreed that the relative work value of 92132 should be the same as 92025. **The RUC recommends a relative work value for 92132 of 0.35.**

New Technology
The RUC recommends that 92132 be placed on the new technology/new service list.

Practice Expense: The RUC reviewed the direct practice expense inputs for new code 92132 and reduced the clinical labor time and supplies for the typical patient service, as an evaluation and management service is typically provided on the same day, and agreed to by the specialty.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
●92132	NN1	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	XXX	0.35
Category III				
D 0187T		~~Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral~~ (0187T has been deleted. To report, use 92132)		N/A

522

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92132 Tracking Number NN1 Specialty Society Recommended RVU: **0.42**

Global Period: XXX RUC Recommended RVU: **0.35**

CPT Descriptor: Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year old male complains of inability to read small print clearly. The patient had temporal narrowing of the anterior chamber angle in the left eye. Imaging is ordered to evaluate the risk of angle closure.

Percentage of Survey Respondents who found Vignette to be Typical: 77%

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

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

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

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

Moderate Sedation

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

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

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

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Description of Pre-Service Work: The patient is examined to ensure the ability to fixate with the eye not being scanned. The test procedures are described to the patient.

Description of Intra-Service Work: The patient is positioned in the instrument. The scanner is aligned with the eye to be examined while the other eye follows a fixation light in order to bring the anterior chamber angle into position. Once the data have been processed by the computer, and examined for quality, they are stored. The image is displayed. The physician evaluates the quality of the study and then interprets the findings. If the current study is a follow-up, an evaluation of interval change is provided. Analysis and report is prepared and sent to the requesting physician.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010		
Presenter(s):	Stephen A. Kamenetzky, M.D., Cindie Mattox, M.D. and Michael Chaglasian, O.D.		
Specialty(s):	AAO/AAO		
CPT Code:	92132		
Sample Size:	230	**Resp N:** 30	**Response:** 13.0 %
Sample Type:	Random	**Additional Sample Information:** Random sample of U.S. members from the membership database of both the Academy, the American Glaucoma Society and the AOA	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**12.50**	46.25	50.00
Survey RVW:	0.00	0.42	**0.52**	0.66	0.99
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	5.00	**10.00**	11.50	30.00

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

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

Specialty Society Recommended Data

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

CPT Code:	92132	**Recommended Physician Work RVU: 0.42**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**3.00**	**0.00**	**3.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Immediate Post Service-Time:	**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:
s this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
76513	XXX	0.66	**RUC Time**

CPT Descriptor Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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**	14,267,661

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	**RUC Time**	2,526,695

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 uantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

Other Reference CPT Code	Global	Work RVU	Time Source
92020	XXX	0.37	**RUC Time**

CPT Descriptor Gonioscopy (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: 9 **% of respondents:** 30.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 92132**	**Key Reference CPT Code: 76513**	**Source of Time RUC Time**
Median Pre-Service Time	3.00	0.00	
Median Intra-Service Time	10.00	19.00	
edian Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Total Time	**13.00**	**19.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.44	3.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.67
Urgency of medical decision making	3.78	3.78
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.56	3.67
Physical effort required	2.67	2.78
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.11	3.22
Outcome depends on the skill and judgment of physician	3.33	3.56
Estimated risk of malpractice suit with poor outcome	3.22	3.44

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.11	3.11
Intra-Service intensity/complexity	3.33	3.44
Post-Service intensity/complexity	3.44	3.56

Additional Rationale and Comments

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

This code was presented to CPT by industry to obtain a value for technology that provides an image of the anterior segment of the eye. Previously this technology was used to image the posterior segment such as the optic nerve or retina. This code will replace the "T" code currently in place for the technology (0187T)

The survey produced 30 responses (13% response rate) and 77% felt that the vignette was typical. The 25th percentile was 0.42, the median 0.52 and the 75th 0.66 WRVU. Median intra-service time was 10 minutes with 10 minutes each of pre- and post-time. The reference code chosen most often was 76513 *Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy*, which has a WRVU of 0.66. This reference code is unilateral in coverage. The code would typically be accompanied by an E/M visit,

An expert consensus panel composed ophthalmologists and optometrists familiar with the RUC process and the testing process reviewed the survey results. The group felt that the times were too long, particularly the pre-service time. In keeping with the prior RUC judgment that the work of this service is in the interpretation and report, we adjusted all of the times to conform to that template. **The times being submitted are 3/10/0 minutes.** The survey respondents felt that the mental effort and judgment, physical effort, technical skill and psychological stress were essentially the same as for the reference code and the panel agreed. Total time for the reference code is longer, while the code is RUC reviewed the times are based on an older CMS determination. It was felt that the 25th percentile value from the survey accurately represented the work of this procedure. **Therefore the society recommends 0.42 WRVU.**

There are other RUC-valued XXX global codes with relatively short times that have similar work values. Gonioscopy (92020) is also a unilateral or bilateral code, RUC reviewed, with slightly longer times and a WRVU of 0.37. CPT 71020 (Chest x-ray) is RUC reviewed and a MPC with a WRVU of 0.22 despite having only 3 minutes of intra-service time and total time of 5 minutes. CPT 92025 (corneal topography) is recently RUC reviewed with similar times and an RVU of 0.35 for unilateral or bilateral use. CPT 92083 also has similar times, the same amount of data to be reviewed and a WRVU of 0.50.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

	CPT Code	Pre	Intra	Post-	Total Time	Work RVU	Global Period
4.	92002	5	15	5	25	.88	XXX
5.	92004	5	25	10	40	1.82	XXX
6.	92012	5	15	5	25	.92	XXX
7.	92014	5	24	8	37	1.42	XXX

CPT Code: 92132

8.	99213	3	15	5	23	.97	XXX

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0187T

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

Specialty Ophthalmology How often? Sometimes

Specialty Optometry 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. Based on information from the company's CPT application

Specialty Opthalmology Frequency 6500 Percentage 65.00 %

Specialty Optometry Frequency 3500 Percentage 35.00 %

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. Estimate

Specialty Ophthalmology Frequency 3250 Percentage 65.00 %

Specialty Frequency 1750 Percentage 35.00 %

Specialty Frequency 0 Percentage 0.00 %

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

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 92020

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

	A	B	C	D	E
1	**AMA/Specialty Society RVS Update Committee Recommendation**				
2				**92132**	
3	**Meeting Date: April 2010**			**Scanning computerized ophthalmic diagnostic imaging; with interpretation and report, unilateral or bilateral; anterior segment**	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**
5	**GLOBAL PERIOD**			**xxx**	**xxx**
6	**TOTAL CLINICAL LABOR TIME**			**15.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**2.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**13.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**
10	**PRE-SERVICE**				
11	**Start: Following visit when decision for surgery or procedure made**				
12	Complete pre-service diagnostic & referral forms	L038A	COMT/COT/RN/CST	**2**	
13	Coordinate pre-surgery services				
14	Schedule space and equipment in facility				
15	Provide pre-service education/obtain consent				
16	Follow-up phone calls & prescriptions				
17	Other Clinical Activity (please specify)				
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	Greet Patient and Provide Gowning, Ensure Appropriate Medical Records Are Available	L038A	COMT/COT/RN/CST		
23	Obtain vital signs				
24	Provide pre-service education/obtain consent				
25	Prepare room, equipment, supplies	L038A	COMT/COT/RN/CST	**2**	
26	Setup scope (non facility setting only)				
27	Prepare and position patient/ monitor patient/ set up IV	L038A	COMT/COT/RN/CST	**2**	
28	Sedate/apply anesthesia				
29	**Intra-service**				
30	Assist physician in performing procedure	L038A	COMT/COT/RN/CST	**6**	
31	**Post-Service**				
32	Monitor pt. following service/check tubes, monitors, drains				
33	Clean room/equipment by physician staff	L038A	COMT/COT/RN/CST	**3**	
34	Clean Scope				
35	Clean Surgical Instrument Package				
36	Complete diagnostic forms, lab & X-ray requisitions				
37	Review/read X-ray, lab, and pathology reports				
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
39	Discharge day management 99238 --12 minutes				
40	Other Clinical Activity (please specify)				
41	**End: Patient leaves office**				
42	**POST-SERVICE Period**				
43	**Start: Patient leaves office/facility**				
44	Conduct phone calls/call in prescriptions				
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**	**CMS Code**	**Unit**		
57			None		
58					
59					
60	**Equipment**	**CMS Code**			
61	Scanning laser device $80K	EQ237		**13.0**	
62	Lane, screening	EL006		**13.0**	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2010

Diabetic Retinopathy Imaging

In February, 2010 the CPT Editorial Panel established two codes for reporting remote imaging for screening retinal disease and management of active retinal disease. CPT code 92227 *Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral* has no physician work and has practice expense inputs only. CPT code 92228 *Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral* has both physician work and practice expense inputs.

535

The RUC reviewed the specialty survey results from 33 ophthalmologists and optometrists for new code 92228 *Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral.* The RUC agreed with 5 minutes pre-service time accurately reflects the typical patient scenario involving positioning of the patient before the retinal camera. The RUC recommends the following physician time for this service: pre-service time of 5 minutes, intra-service time of 8 minutes and 0 minutes post service. The respondents indicated, and the RUC agreed, that CPT code 92250 *Fundus photography with interpretation and report* (Work RVU = 0.44, 9 minutes of intra-service time and 5 minutes immediate post), was virtually identical in physician work, time, and intensity as new code 92228 and should be valued the same. A value of 0.44 is also the 25th percentile survey work value. **The RUC recommends a work relative value of 0.44 for CPT code 92228.**

New Technology: The RUC recommends that 92228 be placed on the new technology/new service list.

Practice Expense: The RUC reviewed the typical practice expense inputs for codes 92227 and 92228 and agreed upon recommendations for both the non-facility and the facility settings.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●92227	OO1	Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral (Do not report 92227 in conjunction with 92002-92014, 92133, 92134, 92250, 92228 or with the evaluation and management of the single organ system, the eye, 99201-99350)	XXX	(Practice Expense Inputs Recommendation Only
●92228	OO2	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral. (Do not report 92228 in conjunction with 92002-92014, 92133, 92134, 92250, 92227 or with the evaluation and management of the single organ system, the eye, 99201-99350)	XXX	0.44

536

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92228 Tracking Number OO2 Specialty Society Recommended RVU: **0.44**

Global Period: XXX RUC Recommended RVU: **0.44**

CPT Descriptor: Remote imaging for monitoring and management of active retinal disease (eg. diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old female with an 11 year history of diabetes mellitus controlled with insulin. The patient is known to have background diabetic retinopathy.

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

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

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

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work: The patient is referred for screening imaging of the retina. Consent is obtained and the pupils dilated. Patient's interval history if available and previous photographs are reviewed.

Description of Intra-Service Work: The patient is positioned before the retinal camera and images of each eye are obtained. The images are forwarded to the reading center. At the reading center a physician reviews the images. An interpretation is prepared by a physician and a report sent to the referring provider

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010		
Presenter(s):	Stephen A. Kamenetzky, M.D. and Michael Chaglasian. O.D.		
Specialty(s):	AAO/AOA		
CPT Code:	92228		
Sample Size:	230	**Resp N:** 33	**Response:** 14.3 %
Sample Type:	Random **Additional Sample Information:** Random sample of U.S. members from the membership database of both the Academy, the American Society of Retinal Specialtists and the AOA		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	30.00	1500.00
Survey RVW:	0.30	0.44	**0.50**	0.78	1.42
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	**8.00**	10.00	27.00

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: XXX Global Code

CPT Code:	92228	**Recommended Physician Work RVU: 0.44**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**8.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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:
's this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92250	090	0.44	**RUC Time**

CPT Descriptor Fundus photography with interpretation and report

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.22	**RUC Time**	14,267,661

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.48	**RUC Time**	20,255,798

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or 'oordination of care with other providers or agencies are provided consistent with the nature 'f the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
92025	XXX	0.35	**RUC Time**

CPT Descriptor Corneal topography

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 57.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 92228**	**Key Reference CPT Code: 92250**	**Source of Time RUC Time**
Median Pre-Service Time	5.00	0.00	
'edian Intra-Service Time	8.00	9.00	
Median Immediate Post-service Time	0.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	**13.00**	**14.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.47	3.37
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.16	3.26
Urgency of medical decision making	3.37	3.32
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.05	2.95
Physical effort required	2.47	2.37
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.32	3.32
Outcome depends on the skill and judgment of physician	3.68	3.58
Estimated risk of malpractice suit with poor outcome	3.74	3.42

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.53	2.63
Intra-Service intensity/complexity	2.89	2.89
Post-Service intensity/complexity	2.89	2.89

Additional Rationale and Comments

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

This code is being presented to allow determination of a work value for remote examination and monitoring of patients with active retinal disease, most commonly diabetic retinopathy. It differs from a screening exam in that the patients are known to have pathology. It is typically performed with an EM examination, but that examination is not performed by the physician reviewing the photographs.

The survey produced 33 responses (14% response rate) and 82% felt that the vignette was typical. The 25th percentile was 0.44 and the median 0.50 WRVU. Median intra-service time was 8 minutes with 5 minutes each of pre- and post time. The reference code chosen most often was 92250 *Fundus photography with interpretation and report*, which has a WRVU of 0.44, is an MPC code and is unilateral or bilateral in coverage, the same as the code being surveyed.

An expert consensus panel composed ophthalmologists and optometrists familiar with the RUC process and fundus photography techniques reviewed the survey results. In keeping with the prior RUC judgment that the work of this service is in the interpretation and report, we adjusted the times somewhat to conform to that template. The suggested times are 5/8/0 minutes. The survey respondents felt that the mental effort and judgment, physical effort, technical skill and psychological stress were essentially the same as for the reference code and the panel agreed. The times are similar as well. It was felt that the 25th percentile survey value, which is identical to the WRVU of the reference code, accurately represented the work of this procedure. **Therefore the society recommends 0.44 WRVU.**

There are other RUC-valued XXX global codes with relatively short times that have similar work values. Gonioscopy (92020) is also a "unilateral or bilateral" code, RUC reviewed, with slightly longer times and a WRVU of 0.37. CPT 71020 (Chest x-ray) is RUC reviewed and MPC with a WRVU of 0.22 despite having only 3 minutes of intra-service time and total time of 5 minutes. CPT 92025 (corneal topography) is recently RUC reviewed with similar times and an RVU of 0.35 for unilateral or bilateral use.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

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

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

Specialty Ophthalmology How often? Sometimes

Specialty Optometry How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 60000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate

Specialty Ophthalmology Frequency 39000 Percentage 65.00 %

Specialty Optometry Frequency 21000 Percentage 35.00 %

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? 6,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate

Specialty Ophthalmology Frequency 3900 Percentage 65.00 %

Specialty Optometry Frequency 2100 Percentage 35.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) 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

AMERICAN ACADEMY OF OPHTHALMOLOGY

American Optometric Association

The following information is provided to clarify the survey data for the service response rate for 922X2 Remote imaging for monitoring and management of active retinal disease (e.g. diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral.

The Academy and the AOA believe that the overall survey results are valid despite the lack of service performance at the 25th and median rates for this service. Reading of remote retinal images is currently provided primarily in the Indian Health Service (IHS) and Veteran's Administration settings. Medicare is currently researching whether or not it should also have a national coverage decision. Because the service is provided for specific federally insured populations, we were limited in finding ophthalmologists and optometrists who have provided this service. The Academy and the AOA retrieved a list of members who designated themselves as having retina training. In addition we sought out members who practice in the VA and IHS settings. For the random list of retina-trained respondents it would be extremely likely that even if they have not consulted on reading remote retinal images, they would be familiar with reading retinal photos that are obtained onsite for their own patients. This is the primary reason why there is a skewed response rate with both the 25th percentile and the median response rates being zero. The rates jump significantly when we look at the 75th percentile and highest rate because they reflect the responses of individuals who provide these services and in some cases devote a significant amount of their time to such screenings.

The Academy segregated the data into groups of those who performed this service and those that did not with the following summary results:

	Number	Concur with typical patient	Primary reference service	25th percentile Wrvu	Median Wrvu
Service Performers	13	69%	92250 *Fundus photo* 38%	.44	.49
Non-performers	20	90%	92250 *Fundus photo* **70%**	.46	.765

The responses of those who performed the service correspond with the overall median and 25th percentile recommended work values exactly. For those who do not perform the service their responses have greater variation in which is reflected in the higher median rate yet the 25th percentile matches closely to the 25th percentile of those who actually provide the service. For this reason, we stand by our recommended value of .44 work RVU's for this service.

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

CPT Long Descriptor:
92227 Remote retinal imaging for screening (e.g., diabetic patient for retinopathy) with analysis under physician supervision, unilateral or bilateral

92228 Remote retinal imaging for management of active disease (e.g., diabetic retinopathy) with physician review and report, unilateral or bilateral

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

The Academy utilizes a work group comprised of clinical staff familiar with the services from both private and academic clinical settings. Input from clinical staff is reviewed and discussed by a consensus committee of the Academy's Health Policy Committee comprised of ophthalmologists 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 reviews the chart to make sure all information is updated and accurate prior to seeing the patient. The camera is cleaned and prepared to take a photograph. Patient demographics are entered into the system. The photos are obtained with a fundus camer equipped with data transmission capabilities. The camera is checked for adequate storage capacity, occasionally requiring backup of the existing photos.

Intra-Service Clinical Labor Activities:

The staff then proceeds to bring patient in exam room and explains the photography to the patient. The patient is positioned properly in the chin rest and given instructions for proper fixation while looking into the instrument. A series of images are obtained. Basic quality measures are reviewed and if insufficient additional images may be acquired. Once the images have been completed and examined for quality, they are stored to the hard disc cache. The patient is then returned to the waiting area.

Post-Service Clinical Labor Activities:

Clinical staff electronically forwards the images to the reading center. The staff then ensures that the camera is cleaned with rubbing alcohol.

	A	B	C	D	E	F	G
1	**AMA/Specialty Society RVS Update Committee Recommendation**						
2				**92227 PE Only Rec**		**92228**	
3	**Meeting Date: April 2010**			**922X1 Remote retinal imaging for screening (eg, diabetic patient for retinopathy) with analysis under physician supervision, unilateral or bilateral**		**922X2 Remote retinal imaging for management of active disease (eg, diabetic retinopathy) with physician review and report, unilateral or bilateral**	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**N/A**	**XXX**	**N/A**
6	**TOTAL CLINICAL LABOR TIME**		L038A	**14.0**	**0.0**	**12.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**		L038A	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**		L038A	**12.0**	**0.0**	**12.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**2.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms						
13	Coordinate pre-surgery services						
14	Schedule space and equipment in facility						
15	Provide pre-service education/obtain consent						
16	Follow-up phone calls & prescriptions						
17	Other Clinical Activity (please specify)						
18	**End:When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters office/facility for surgery/procedure**						
21	**Pre-service services**						
22	Greet Patient and Provide Gowning, Ensure Appropnate Medical Records Are Available						
23	Obtain vital signs						
24	Provide pre-service education/obtain consent						
25	Prepare room, equipment, supplies		L038A	**2**		**2**	
26	Setup scope (non facility setting only)						
27	Prepare and position patient/ monitor patient/ set up IV		L038A	**2**		**2**	
28	Sedate/apply anesthesia						
29	**Intra-service**						
30	Assist physician in performing procedure		L038A	**6**		**6**	
31	**Post-Service**						
32	Monitor pt following service/check tubes, monitors, drains						
33	Clean room/equipment by physician staff						
34	Clean Scope						
35	Clean Surgical Instrument Package						
36	Complete diagnostic forms, lab & X-ray requisitions						
37	Review/read X-ray, lab, and pathology reports						
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
39	Discharge day management 99238 --12 minutes						
40	transmit images to remote reading center		L038A	**2**		**2**	
41	**End: Patient leaves office**						
42	**POST-SERVICE Period**						
43	**Start: Patient leaves office/facility**						
44	tech reads photos		L038A	**2**			
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							
54	*Total Office Visit Time*			**0**	**0**	**0**	**0**
55	Other Activity (please specify)						
56	**End: with last office visit before end of global period**						
57	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**				
58	tropicamide 1% ophth (Mydriacyl)	SH073	ml	**1**		**1**	
59							
60							
61	**Equipment**	**CMS Code**	**Utilization Percentage**				
62	camera, remote retinal imaging	ED008		**12**		**12**	
63							

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2010

Chemotherapy Administration Into Peritoneal Cavity

The CPT Editorial Panel created one code and deleted 96445 *Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis* to provide updated specificity of the standard of practice for chemotherapy administration into the peritoneal cavity. New code 96446 *Chemotherapy administration into the peritoneal cavity via indwelling port or catheter* identifies intraperitoneal chemotherapy performed concurrently with debulking of a cancerous ovary.

The RUC reviewed the specialty society's survey results for new code 96446 and agreed that the survey respondents misunderstood the service being surveyed as the work RVU values were overstated. Survey respondents indicated that current work RVUs and physician time components were similar for surveyed code, 96446 and for the code that it is replacing, 96445 *Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis* (Work RVU = 2.20), even though the original code included peritoneocentisis, which the new code does not. As the survey data did not accurately reflect the physician work for the surveyed code, the RUC agreed to establish work RVU values based on the existing RUC-approved chemotherapy codes.

549

The RUC reviewed the chemotherapy code that most closely resembles 96446, 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug* (Work RVU = 0.28, pre, intra, and post time of 4, 7, and 2 minutes respectively), with an intra-service work intensity of 0.0204. The RUC understood that interperitoneal (IP) chemotherapy administration is more complex than intravenous (IV) administration, and requires additional preparation and post-therapy work. Additional drugs are used with IP chemotherapy, which increases the risk of toxicity and adverse events. Lastly, patients getting IP chemotherapy typically have more severe symptoms, and the additional fluid in the peritoneal cavity often causes shortness of breath and pain that requires the physician's attention.

The RUC agreed with the specialty that these patients need additional management and have additional complications that require additional pre and post service physician time and work. The RUC agreed that the physician time components of 5 minutes pre-service evaluation, 7 minutes intra-service time, and 5 minutes immediate post time were appropriate for this service, resulting in an intra-service work per unit of time of 0.02086. Given these additional minutes of service time of the surveyed code in comparison to the reference code, the RUC added an increment of work RVUs to the reference code to accurately account for these increases in time valuing the surveyed service at 0.37 work RVUs. The RUC also reviewed the specialty's key reference service, 96416 *Chemotherapy*

administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump (Work RVU = 0.21, total time = 10 minutes) 94453 *High altitude simulation test (HAST), with physician interpretation and report; with supplemental oxygen titration* (Work RVU = 0.40, 23 minutes total time) and multispecialty points of comparison code 95900 *Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study* (Work RVU = 0.42, 14 minutes total time), in relation to new code 96446, and agreed it that 0.37 work RVUs properly rank orders the surveyed service amongst all physician services. **The RUC recommends a relative work value of 0.37 for CPT code 96446.**

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

Practice Expense: The RUC reviewed the direct practice expense inputs for CPT code 96446, made some minor reductions to the specialty recommended clinical labor time and medical supplies to reflect the typical patient service.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 96445		~~Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis~~ (96445 has been deleted. To report chemotherapy administration, use 96446)	000	N/A
•96446	RR1	Chemotherapy administration into the peritoneal cavity via indwelling port or catheter	XXX	0.37

550

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:96446 Tracking Number RR1 Specialty Society Recommended RVU: **0.37**

Global Period: XXX RUC Recommended RVU: **0.37**

CPT Descriptor: Chemotherapy administration into the peritoneal cavity via indwelling port or catheter

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 62 year old female with advanced stage ovarian cancer, has undergone optimal surgical debulking of her cancer, and an intraperitoneal catheter with a subcutaneous port was placed for subsequent chemotherapy. She now presents for postoperative intraperitoneal chemotherapy.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 19%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 15%

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

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Description of Pre-Service Work: ☐ Physician provides and confirms orders
☐ Physician interacts and reviews plan with staff
☐ Physician confirms and reviews lab results
☐ Physician calculates chemotherapy dose
☐ Physician makes any adjustments in IP chemotherapy regimen based on evidence of ongoing chemotherapy side effects from previous cycles

Description of Intra-Service Work: ☐ Physician provides direct supervision
☐ Physician is immediately available for any problems related to accessing the IP port reservoir
☐ Physician assesses patient's response to treatment
☐ Physician is immediately available for symptom management due to abdominal distention from the chemotherapy and dilutional fluids

Description of Post-Service Work: ☐ Physician provides appropriate instructions regarding immediate care
☐ Physician provides instructions for symptom management after IP chemotherapy instillation
☐ Physician provides instructions regarding ongoing care
☐ Physician conducts appropriate interactions with staff regarding patient monitoring

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Gary Leiserowitz, MD; George Hill, MD; David Regan, MD; Willaim Robinson, MD				
Specialty(s):	ACOG, ASCO, SGO				
CPT Code:	96446				
Sample Size:	870	**Resp N:**	82	**Response:** 9.4 %	
Sample Type:	Random	**Additional Sample Information:**	All SGO members + select ASCO mbrs		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**12.00**	24.00	250.00
Survey RVW:	0.21	1.50	**2.21**	2.50	10.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	5.00	15.00	**30.00**	60.00	280.00

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: XXX Global Code

CPT Code:	96446	**Recommended Physician Work RVU: 0.37**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**7.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
96416	XXX	0.21	**RUC Time**

CPT Descriptor Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable 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
94060	XXX	0.31	**RUC Time**	1,210,026

CPT Descriptor 1 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,367,407

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 20.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 96446**	**Key Reference CPT Code: 96416**	**Source of Time RUC Time**
Median Pre-Service Time	5.00	4.00	
Median Intra-Service Time	7.00	4.00	
Median Immediate Post-service Time	5 00	2.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
1edian Office Visit Time	0.0	0.00	
rolonged Services Time	0.0	0.00	
Median Total Time	**17.00**	**10.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.82	3.65
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.12	3.94
Urgency of medical decision making	3.82	3.76
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.71	3.53
Physical effort required	3.47	3.18
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.47	4.00
Outcome depends on the skill and judgment of physician	4.29	4.06
Estimated risk of malpractice suit with poor outcome	3.59	3.59

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.06	3.53
Intra-Service intensity/complexity	3.94	3.41
Post-Service intensity/complexity	3.71	3.18

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 recognized that the time and RVU values from the survey were significantly too high. Survey respondents indicated that current work RVUs and times were pretty much the same for the new code for interperitoneal chemotherapy, 96446, and for the code that it is replacing, 96445, even though the original code included peritoneocentisis, which the new code does not. It was therefore necessary to establish reasonable time and RVU values based on existing chemotherapy codes.

The RUC reviewed code that most closely resembles 96446 is 96413, *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug*, with 0.28 work RVU, pre-, intra-, and post- times of 4-7-2 minutes, and IWPUT of 0.0204. IP chemotherapy administration is more complex than IV administration, and requires additional preparation and post-therapy work. Additional drugs are used with IP chemotherapy, increasing risk of toxicity and adverse events. Patients getting IP chemo typically have more severe symptoms, and the additional fluid in the peritoneal cavity often causes shortness of breath and pain that require the physician's attention. Appropriate pre-, intra-, and post-times are 5-7-5 minutes. The 25 percentile times from the survey were 20-15-10 minutes.

IWPUT calculation:
Proposed work RVU: 0.37

Pre-service Eval: 5 min X 0.0224 = 0.11
Postservice: 5 min X 0.0224 = 0.11

0.15 RVU remaining

Intra- time: 7 min

IWPUT: 0.02086

99215 was chosen as the appropriate reference service by slightly more respondents than 96416, but the expert panel recognized that 96416 is more similar, so it was used for comparison in the SOR. 99215 has an IWPUT of 0.0475. 96446 would need an RVW of 0.56 to achieve that IWPUT.

SERVICES REPORTED WITH MULTIPLE 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. When giving cisplatin either IV or IP, IV hydration is standard of care to prevent renal damage. IP cisplatin is harder to give than IP paclitaxel. Other possible IP chemo agents (e.g., carboplatin) are under investigation and might not require concomitant IV hydration.
3.
4. 96360, Intravenous infusion, hydration; initial, 31 minutes to 1 hour
5. XXX global period,
6. Work RVU: 0.17
7. Times (minutes):
8. Pre 2
   Intra 3
10. Post 2

An additional drug is also sometimes administered prior to the administration of the chemotherapy. In that case, it is appropriate to use 96374.

96374 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
XXX global
Work RVU: 0.18
Times (minutes):
Pre 2
Intra 5
Post 2

None of these times are included in the times for 96446.

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 gyn/onc How often? Commonly

Specialty hem/onc How often? Sometimes

Specialty med/onc How often? Sometimes

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 Gyn/onc	Frequency 1200	Percentage 40.00 %
Specialty hem/onc	Frequency 600	Percentage 20.00 %
Specialty med/onc	Frequency 350	Percentage 11.66 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,500
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Current utilization - RUC database

Specialty gyn/on	Frequency 600	Percentage 40.00 %
Specialty hem/onc	Frequency 300	Percentage 20.00 %
Specialty med/onc	Frequency 174	Percentage 11.60 %

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 96413

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

CPT Code: 96446

AMA/Specialty Society
Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: 96446 Chemotherapy administration into peritoneal cavity

Description of the process used to develop your recommendation and the composition of the Specialty Society Practice Expense Committee:

The Society of Gynecologic Oncologists (SGO), the American Society of Clinical Oncology (ASCO) and the American Congress of Obstetricians and Gynecologists (ACOG) participated in developing PE and work RVU recommendations for code 96446, which is replacing 96445, IP chemotherapy that included peritoneocentesis, which the new code does not include. Several members of the SGO Coding Committee reviewed the current inputs for 96445 and provided their recommendations independently from one another. Nurses who work in a major university setting and nurses in a small private practice provided recommendations for time, supplies and equipment. The SGO physicians developed the description of staff clinical activities, with input and feedback from the nurses who provide the services. A consensus panel of two SGO physicians, two ASCO physicians, and one physician from ACOG reviewed all PE inputs, including supplies, equipment, and non-physician clinical activities and times.

Clinical activities of staff:

Pre-Service Clinical Labor Activities: All pre-service work is performed by an RN/ONC (L056A) who completes the pre-service diagnostic and referral forms and coordinates services. This includes confirming orders and authorization for the IP chemotherapy and drugs, confirming the schedule to ensure that an infusion bed is available, that the chemotherapy drugs are in stock, and that the results of recent diagnostic tests are available and have been reviewed.

Intra-Service Period Clinical Labor Activities: All intra-service work is performed by an RN/ONC (L056A) who reviews the patient's chart to determine the prescribed course of treatment and obtains a chemotherapy related history and any interval changes in medical history which includes reconciliation of medications and allergies. The patient is greeted and vital signs are obtained. Pre-service education is provided including an explanation of the series of movements required by the patient and the importance of compliance with nursing instructions to maximize drug distribution within the peritoneal cavity and to avoid dislodging the access needle. Anticipated side effects both during and following the infusions are reviewed. Consent is obtained for treatment.

The RN/ONC assembles the necessary supplies and prepares the room. Either the RN/ONC or the pharmacist prepares the dosage based on the physician's written order. The dosage is re-calculated to ensure the prescribed calculations are appropriate. The RN/ONC programs the infusion pump and rechecks dosage calculations if the chemotherapy was mixed by the pharmacist. The patient is placed in supine position. The RN/ONC prepares the site of the IP access device in sterile fashion. The reservoir is typically located in the subcutaneous fat on the lower chest wall below the breast in the mid-clavicular line thus requiring more effort to locate and manipulate than an IV access. The reservoir is stabilized manually by the RN/ONC who accesses it using a 2"Huber needle. Patency is confirmed. If the nurse cannot access the IP port and/or if patency cannot be verified, then the supervising physician is contacted for assistance.

Once port access is obtained, the RN/ONC records a second set of vital signs and begins IP infusion.

The patient is carefully observed in the supine position for the initial 5 minutes. The RN/ONC then directs the patient through a series of position changes at 5 minute intervals including Trendelenburg (head down), reverse Trendelenburg (head up), right side recumbent, and left side recumbent. This series of movements are repeated until the chemotherapeutic agent is completely infused which is at least one hour in the typical patient. After each movement, the RN/ONC rechecks the access device to ensure the needle has not dislodged and records the observation in the clinical record. The RN/ONC obtains and documents vital signs every 15 minutes. The patient is monitored throughout the procedure. If the patient has side effects that cannot be managed with standardized orders, then the supervising physician will be contacted for assistance. Once the drug is completely infused, the RN/ONC hangs dilutional normal saline administered through the access device to maximize drug distribution. Fluids are continued to patient tolerance, which is one liter of NS in the typical patient.

Following completion of the chemotherapy administration, the RN/ONC will de-access the IP device in sterile fashion and will continue to monitor the patient to ensure there are no immediate side effects or complications. The RN/ONC gives instructions regarding side effects, complications, use of medications for post-chemotherapy symptom management, and follow-up plans to the patient. The nurse then cleans the room, and completes the necessary medical documentation.

Post Service Period: The RN/ONC makes necessary calls to the patient and others involved in the care of the patient. The nurse monitors the patient for post-procedure side effects and recommends remedies within nursing protocol and/or contacts the physician for further instructions.

AMA/Specialty Society RVS Update Committee Recommendation				
CHEMOTHERAPY ADMINISTRATION			96446	
			Chemotherapy administration into	
LOCATION	CMS Code	Staff Type	Non Facility	Facility
GLOBAL PERIOD			000	000
TOTAL CLINICAL LABOR TIME	L056A	RN/OCN	133	0
TOTAL PRE-SERV CLINICAL LABOR TIME	L056A	RN/OCN	6	0
TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L056A	RN/OCN	121	0
TOTAL POST-SERV CLINICAL LABOR TIME	L056A	RN/OCN	6	0
PRE-SERVICE				
Start: Following visit when decision for surgery or procedure made				
Complete pre-service diagnostic & referral forms	L056A	RN/OCN	3	
Coordinate pre-surgery services	L056A	RN/OCN	3	
Schedule space and equipment in facility	L056A	RN/OCN		
Provide pre-service education/obtain consent	L056A	RN/OCN		
Follow-up phone calls & prescriptions				
Other Clinical Activity (please specify)				
End: When patient enters office/facility for surgery/procedure				
SERVICE PERIOD				
Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure				
Review charts by chemo nurse regarding course of treatment & obtain chemotherapy-related medical hx	L056A	RN/OCN	5	
Greet patient and provide gowning	L056A	RN/OCN	3	
Obtain vital signs	L056A	RN/OCN	3	
Provide pre-service education/obtain consent (initial education of 1 hr amortized over average of 6 cycles)	L056A	RN/OCN	8	
Prepare room, equipment, supplies	L056A	RN/OCN	2	
Gain IP port access	L056A	RN/OCN	7	
Prepare and position patient/ monitor patient/ set up IV	L056A	RN/OCN	2	
Mix chemotherapy	L056A	RN/OCN	17	
Sedate/apply anesthesia	L056A	RN/OCN		
Intra-service				
Performing procedure	L056A	RN/OCN	60	
Post-Service				
Monitor pt. following service/check tubes, monitors, drains	L056A	RN/OCN	5	
Clean room/equipment by physician staff	L056A	RN/OCN	3	
Complete medical record documentation, diagnostic forms, lab & X-ray requisitions	L056A	RN/OCN	3	
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
Discharge day management 99238 --12 minutes, 99239 --15 minutes				
Post-procedure education/conditions for which patient should call office (side effects, complications) home care instructions/coordinate office visits/prescriptions	L056A	RN/OCN	3	
End: Patient leaves office				
POST SERVICE Period				
Start: Patient leaves office/facility				
Conduct phone calls/call in prescriptions	L056A	RN/OCN	6	
MEDICAL SUPPLIES		Unit		
Minimum supply package	SA048	item	1	
gloves, sterile	SB024	item	1	
gown staff, impervious	SB027	item	1	
infusion pump cassette-reservoir	SC013	item	1	
IV infusion set	SC018	item	1	
needle, Huber 19g, 11/2 - 2"	SC039	item	1	
surgical mask	SB033	item	1	
syringe 10-12ml	SC051	item	3	
swab-pad alcohol	SJ053	item	3	
water sterile, inj	SH075	ml	2	
IV tubing (extension)	SC019	foot	1	
graham crackers, 1 packet	SK040	item	1	
Juice, apple, 1 ounce	SK042	oz	6	
cup, drinking	SK018	item	1	
Sodium chloride, 0 9%, 1000cc	SH069	item	1	
sodium chloride, 0 9% inj bacteriostatic	SH068	item	1	
heparin, 1000 units-ml inj	SH039	ml	1	
swab, patient pre, 1 5 ml (chloraprep)		item	1	
gauze, 2in X 2in	SG053	item	1	
mask, surgical, with face guard	SB034	item	1	
gloves, non-sterile, nitrile	SB023	item	2	
4X4 Tegaderm	SG037	item	1	
Equipment				
bed, hospital, electric**	EF002		101	
biohazard hood	EP016		17	
IV infusion pump	EQ032		101	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2009

Subsequent Observation Services

Shifts in practice and payment policy have made it increasingly common for patients to remain in a hospital for several days under observation or outpatient status, instead of being "admitted." The RUC has had several discussions pertaining to valuing the 23+ hour codes and has resorted to using work proxies in order to capture the work being performed in these services. As currently, in CPT, there are only codes to report the initial day of observation service and discharge from observation. CPT advice for "subsequent" observation services has directed that code 99499 *Unlisted evaluation and management service* be reported for subsequent days. In response to the increase in the number of observation services that extend beyond the initial observation, a CPT coding proposal was prepared to request subsequent care observation codes to allow providers to report these services. At the June 2009 CPT meeting, three new codes were approved to report subsequent observation services in a facility setting.

563

99224 Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

The RUC reviewed the survey data as presented from the American College of Physicians and the American College of Surgeons for 99224. The specialty societies presented modifications to the pre-service time package selected 1A (total pre-service time-20 minutes) to reflect their survey data of 5 minutes of evaluation time as the remainder of the pre-service time associated with this package was not reflective of the service provided. Further, the specialty societies recommend the 25th percentile for the intra-service time, 20 minutes, and 5 minutes of post-service time as they agreed that the intra-service time and the post-service times for the new codes should be the same as the reference code 99231 *Subsequent hospital care, per day, for the evaluation and management of a patient,* (Work RVU=0.76). After reviewing the service times as recommended by the specialty societies, the RUC compared the reference code to the surveyed code and determined that both services require similar intensity and complexity to perform. Given that the recommended times for 99224 are the same as the reference code and that the intensity and complexity of performing 99224 is the same as the reference code,

the specialty societies recommended that 99224 should have the same work RVU as 99231, 0.76 work RVUs, which is also the survey 25th percentile. **The RUC recommends 0.76 work RVUs for 99224.**

99225 Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

The RUC reviewed the survey data as presented from the American College of Physicians and the American College of Surgeons for 99225. The specialty societies presented modifications to the pre-service time package selected 2A (total pre-service time-25 minutes) to 10 minutes of evaluation time as the remainder of the pre-service time associated with this package was not reflective of the service provided. Further, the specialty societies recommend the survey median for the intra-service time, 20 minutes, and 10 minutes of post-service time as they agreed that the intra-service time and the post-service times for the new codes should be the same as the reference code 99232 *Subsequent hospital care, per day, for the evaluation and management of a patient,* (Work RVU=1.39). After reviewing the service times as recommended by the specialty societies, the RUC compared 99225 to the reference code and determined that both services require similar intensity and complexity to perform. Given that the recommended times for 99225 are the same as the reference code and that the intensity and complexity of performing 99225 is the same as the reference code, the specialty societies recommended that 99225 should have the same work RVU as 99232, 1.39 work RVUs, which is just below the survey median (1.40 Work RVUs). **The RUC recommends 1.39 work RVUs for 99225.**

564

99226 Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least two of these three 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.

The RUC reviewed the survey data as presented from the American College of Physicians and the American College of Surgeons for 99226. The specialty societies presented modifications to the pre-service time package selected 2A (total pre-service time-25 minutes) to reflect their survey data of 10 minutes of evaluation time as the remainder of the pre-service time associated with this package was not reflective of the service provided. Further, the specialty societies recommend the intra-service time, 30 minutes, and 15 minutes of post-

service time as they agreed that the intra-service time and the post-service time for the new codes should be the same as the reference code 99233 *Subsequent hospital care, per day, for the evaluation and management of a patient,* (Work RVU=2.00). After reviewing the service times as recommended by the specialty societies, the RUC compared 99226 to the reference code and determined that both services require similar intensity and complexity to perform. Given that the recommended times for 99226 are the same as the reference code and that the intensity and complexity of performing 99226 is the same as the reference code, the specialty societies recommended that 99226 should have the same RVUs as 99233, 2.00 work RVUs, which is the survey median. **The RUC recommends 2.00 work RVUs for 99226.**

Practice Expense Inputs: Similar to the other facility-only evaluation and management services, including the subsequent hospital care, the RUC recommends no practice expense inputs for these services.

CPT Follow-up: The RUC recommends that the language, "Physicians typically spend XX minutes at the bedside and on the patient's hospital floor or unit" in the descriptors of 99224-99226 match the times as stated in the descriptors of the subsequent hospital visit services 99231-99233.

565

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
The following codes are used to report evaluation and management services provided to patients designated/admitted as "observation status" in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital. *If such an area does exist in a hospital (as a separate unit in the hospital, in the emergency department, etc.), these codes are to be utilized if the patient is placed in such an area.* *For definitions of key components and commonly used terms, please see* ***Evaluation and Management Services Guidelines.*** ~~Typical times have not yet been established for this category of services.~~				
Initial Observation Care **New or Established Patient**				
The following codes are used to report the encounter(s) by the supervising physician with the patient when designated as "observation status." This refers to the initiation of observation status, supervision of the care plan for observation and performance				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
of periodic reassessments. For observation encounters by other physicians, see Office or Other Outpatient Consultation codes (99241-99245) or subsequent observation care codes (99224-99226) as appropriate. To report services provided to a patient who is admitted to the hospital after receiving hospital observation care services on the same date, see the notes for initial hospital inpatient care (page 14). For observation care services on other than the initial or discharge date, see subsequent observation services codes (99224-99226). For a patient admitted to the hospital on a date subsequent to the date of observation status, the hospital admission would be reported with the appropriate Initial Hospital Care code (99221-99223). For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate. Do not report observation discharge (99217) in conjunction with a hospital admission. When "observation status" is initiated in ... Evaluation and management services on the ... These codes may not be utilized ...				
Subsequent Observation Care All levels of subsequent observation care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (ie, changes in history, physical condition, and response to management) since the last assessment by the physician.				
•99224	F1	**Subsequent observation care,** per day, for the evaluation and management of a patient, which requires at least two of these three key components: • Problem focused interval history; • Problem focused examination; • Medical decision making that is straightforward or of low complexity Counseling and/or coordination of care with other providers or agencies are provided	XXX	0.76

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.		
•99225	F2	**Subsequent observation care,** per day, for the evaluation and management of a patient, which requires at least two of these three key components: • An expanded problem focused interval history; • An expanded problem focused examination; • Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.	XXX	1.39
•99226	F3	**Subsequent observation care,** per day, for the evaluation and management of a patient, which requires at least two of these three 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.	XXX	2.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		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.		

Hospital Inpatient Services

The following codes are used to report evaluation and management services provided to hospital inpatients. Hospital inpatient services include those services provided to patients in a "partial hospital" setting. These codes are to be used to report these partial hospitalization services. See also psychiatry notes in the full text of the CPT codebook.

For definitions of key components and commonly used terms, please see Evaluation and Management Services Guidelines. For Hospital Observation Services, see 99218-99220, 99224-99226. For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate.

Observation or Inpatient Care Services (Including Admission and Discharge Services)

The following codes are used to report observation or inpatient hospital care services provided to patients admitted and discharged on the same date of service. When a patient is admitted to the hospital from observation status on the same date, the physician should report only the initial hospital care code. The initial hospital care code reported by the admitting physician should include the services related to the observation status services he/she provided on the same date of inpatient admission.

When "observation status" is initiated in the course of an encounter in another site of service (eg, hospital emergency department, physician's office, nursing facility) all evaluation and management services provided by the supervising physician in conjunction with initiating "observation status" are considered part of the initial observation care when performed on the same date. The observation care level of service should include the services related to initiating "observation status" provided in the other sites of service as well as in the observation setting when provided by the same physician.

For patients admitted to observation or inpatient care and discharged on a different date, see codes 99218-99220, 99224-99226 and 99217, or 99221-99223 and 99238, 99239.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99224 Tracking Number F1 Specialty Society Recommended RVU: **0.76**
Global Period: XXX RUC Recommended RVU: **0.76**

CPT Descriptor: Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: Problem focused interval history; problem focused examination; medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Subsequent observation care of a 42-year-old male following an uncomplicated mandible fracture who is responding to pain medication; however he is not controlled on oral medications and requires continued observation.

Percentage of Survey Respondents who found Vignette to be Typical: 77%

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

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work:
Review data not available on the unit (eg, diagnostic and imaging studies). Communicate with other professionals and with patient or patient's family.

Description of Intra-Service Work:
Review medical records and data available on the unit. (Obtain a problem focused history.*) (Perform a problem focused physical exam.*) (Consider relevant data, options, and risks and formulate/revise diagnosis and treatment plan(s) (straightforward or low complexity medical decision making.*) Discuss diagnosis and treatment options with the patient and/or family. Consider discharge needs of patient. Communicate with other health care professionals. Write/review orders including ordering/arranging for necessary diagnostic testing, consultation and therapeutic intervention(s). Complete medical record documentation. [*Two of these three components are required.]

Description of Post-Service Work:

Address interval data obtained and changes in condition reported. Communicate results and further care plans to other health care professionals and to the patient and/or family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2009				
Presenter(s):	Scott Manaker, MD, FACP; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS				
Specialty(s):	Internal Medicine (ACP); Surgery (ACS)				
CPT Code:	99224				
Sample Size:	290	**Resp N:**	44	**Response:** 15.1 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**20.00**	50.00	500.00
Survey RVW:	0.00	0.76	**0.91**	1.41	5.00
Pre-Service Evaluation Time:			**5.50**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	4.00	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: 1a-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	99224	**Recommended Physician Work RVU: 0.76**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**13.00**	**-8.00**
Pre-Service Positioning Time:		**0.00**	**1.00**	**-1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**6.00**	**-6.00**
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
99231	XXX	0.76	**RUC Time**

CPT Descriptor Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
99462	XXX	0.62	**RUC Time**	4

CPT Descriptor 1 Subsequent hospital care, per day, for evaluation and management of normal newborn

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99202	XXX	0.88	**RUC Time**	2,453,675

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
99307	XXX	0.76	**RUC Time**

CPT Descriptor Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; 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 patient is stable, recovering, or improving. Physicians typically spend 10 minutes with the patient and/or family or caregiver.

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

Number of respondents who choose Key Reference Code: 18 **% of respondents:** 40.9 %

TIME ESTIMATES (Median)	CPT Code: 99224	Key Reference CPT Code: 99231	Source of Time RUC Time
Median Pre-Service Time	5.00	5.00	

Median Intra-Service Time	10.00	10.00
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	**20.00**	**20.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.22	2.06
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.33	2.17
Urgency of medical decision making	2.22	1.69
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.11	2.06
Physical effort required	1.59	1.76
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.12	2.12
Outcome depends on the skill and judgment of physician	2.41	2.35
Estimated risk of malpractice suit with poor outcome	2.59	2.41

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.00	1.94
Intra-Service intensity/complexity	2.44	2.28
Post-Service intensity/complexity	2.06	1.94

Additional Rationale and Comments

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.*

Background

Shifts in practice and payment policy have made it increasingly common for patients to remain in a hospital for several days under observation or outpatient status, instead of being "admitted." This is evidenced by a recent newspaper article: Graham, J. Hospitals' use of 'observation stay' is questioned. Chicago Tribune. March 9, 2009. [http://archives.chicagotribune.com/2009/mar/09/local/chi-observation-caremar09]. Currently, in CPT, there are only codes to report the initial day of observation service and discharge from observation. CPT advice for "subsequent" observation services has directed that code 99499 *Unlisted evaluation and management service* be reported for subsequent days. In response to the increase in the number of observation services that extend beyond the initial observation, the CPT Editorial Panel Executive Committee directed AMA staff to prepare a proposal to request subsequent care observation codes to allow providers to report these services. At the June 2009 CPT meeting, three new codes were approved to report subsequent observation services in a facility.

Survey Data

The American College of Physicians (ACP) and the American College of Surgeons (ACS) conducted a RUC survey for new code 992X1. ACP received 28 usable survey responses and ACS received 16 responses. As shown in the table below, the median physician work and times are greater for ACP surveys compare with the same statistics for ACS surveys. This may be due to the fact that only 68% of the ACP respondents indicated the vignette described their typical patient (compared with 94% for ACS surveys). Those respondents that disagreed with the typical patient, indicated that their patients would be more complex (eg, more co-morbidities) and/or have a different presenting problem (eg, cardiac, gastrointestinal, respiratory).

			RVW						INTRA					
	CPT	DESC	MIN	25TH	MED	75TH	MAX	PRE	MIN	25TH	MED	75TH	MAX	POST
REF	99231	Subsequent Hosp - Lev 1			0.76			5			10			5
SVY	99224	Subsequent Observ - Lev 1 (n=44)	0.00	0.76	0.91	1.41	5.00	5.5	4	10	15	20	40	10
	99224	ACS (n=16)	0.60	0.76	0.78	1.00	2.00	5	5	10	10	15	20	5
	99224	ACP (n=28)	0.00	0.76	0.99	1.76	5.00	10	4	10	18	25	40	10

Pre-Service Time:

The Pre-time packages are designed specifically to reflect time required prior to a procedure (in/out of a facility and with/without anesthesia). As a proxy, we recommend Package 1A *Straightforward Patient/Straightforward Procedure (No sedation/anesthesia care)* with the following modifications:

- Evaluation: Subtract 5 minutes for H&P which will be performed during the intra-service component. Subtract 3 minutes for setting up the room, checking patient readiness for a *procedure*, and prepare/review/confirm *procedure*.
- Positioning: Subtract 1 minute – not required.
- Scrub/Dress/Wait: Subtract 6 minutes – not required

These subtractions result in a conservative **pre-time recommendation of 5 minutes** to review data not available on the unit (eg, diagnostic and imaging studies) and communicate with other professionals and with patient or patient's family.

Intra-Service Time

The consensus committee reviewing this data believe the intra-service physician time for new code 99224 is equivalent to the time required for 99231. For both codes, the patient will require at least two of the following three activities: Problem focused interval history; problem focused examination; medical decision making that is straightforward or of low complexity. Although the survey median data may indicate new code 99224 requires more intra-service time, we elieve this may be due to the high percentage of respondents that disagreed with the vignette – ie, the trauma patient was not the typical for their practice. **We recommend 10 minutes for the intra-service time**, which is the same as the intra-service time for 99231.

Post-Service Time

Similar to our comments above for intra-service time, we believe the post-service time for 99224 would be equivalent to the post-service time for 99231. Again, the survey median may be different due to the high percentage of respondents that disagreed with the vignette. **We recommend 5 minutes for the post-service time**, which is the same as the post-service time for 99231.

RVW Recommendation

We recommend the survey 25th percentile RVW of 0.76 which is the same as the RVW for 99231.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99499 or 99231

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

Specialty internal medicine How often? Commonly

Specialty 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 information is not available and cannot be estimated because of the wide variation in hospital policies regarding patient status designation and third party payer rules.

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. Please see attached table with discussion and estimates.

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? (ie. similar work RVU, and specialty) 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

Attachment: Discussion of Medicare Utilization Estimate

In 2007, there were 477,848 Medicare claims reported for discharge from observation status on a date different than initial date of observation. We estimate that 30% of these patients (143,354) would include an additional day of subsequent" observation (ie, Day 1 = initial observation; Day 2 = subsequent observation; and Day 3 = discharge from observation.)

Further, we estimate that the split between the different levels of subsequent observation services corresponding to the new codes 99224 / - 5 / -6 would be 20% / 60% / 20%. This is similar to the distribution for subsequent hospital visit claims.

99217	Obs Dischrg - diff date	477,848
	30 % =	143,354

		Estimated split of 143,354	
99224	SUB OBS Level 1	28,671	20%
99225	SUB OBS Level 2	86,013	60%
99226	SUB OBS Level 3	28,671	20%

As stated in the additional rationale section of this SoR, CPT advice for "subsequent" observation services has directed that code 99499 *Unlisted evaluation and management service* be reported for subsequent days. Because the utilization for 99499 is only 3642, we believe that some reporting for subsequent observation services may have utilized the subsequent hospital visit codes as representative of the physician work to care for patients in a hospital.

We believe that the physician work (and work RVU) for a patient in a hospital bed is the same regardless of a hospital policy assignment of outpatient or inpatient status. Further, although the payment to the facility may be different, the physician work is the same. Therefore, the estimates for utilization of the new codes would be budget neutral regardless of what percentages are estimated because they most logically represent a shift from 99231-99233 to the corresponding 99224-99226.

We also believe the distribution of utilization for the new codes will not be limited to the specialties surveying the codes (internal medicine and general surgery), but instead will mirror the specialty distribution of the subsequent hospital visit codes (99231-99233). Using the most current year available (2007), we estimate the distribution for 99224 to be:

99224:	INTERNAL MEDICINE	24.17%
	CARDIOLOGY	9.00%
	FAMILY PRACTICE	8.74%
	PHYSICAL MEDICINE AND REHABILITATION	7.71%
	PSYCHIATRY	7.58%
	GASTROENTEROLOGY	5.29%
	PULMONARY DISEASE	4.69%
	NEPHROLOGY	4.36%
	GENERAL SURGERY	4.23%
	INFECTIOUS DISEASE	4.07%
	NEUROLOGY	3.67%
	HEMATOLOGY/ONCOLOGY	2.48%
	UROLOGY	1.79%
	ENDOCRINOLOGY	1.63%
	NURSE PRACTITIONERS	1.42%
	GENERAL PRACTICE	1.22%
	PHYSICIANS ASSISTANT	1.09%
	MEDICAL ONCOLOGY	0.89%
	ORTHOPEDIC SURGERY	0.65%

	NEUROSURGERY	0.64%
	EMERGENCY MEDICINE	0.55%
	VASCULAR SURGERY	0.47%
	ANESTHESIOLOGY	0.45%
	CRITICAL CARE (INTENSIVISTS)	0.38%
	GERIATRIC MEDICINE	0.33%
	RHEUMATOLOGY	0.28%
	THORACIC SURGERY	0.28%
	PODIATRY	0.26%
	CARDIAC SURGERY	0.16%
	CERTIFIED CLINICAL NURSE SPECIALIST	0.15%
	HEMATOLOGY	0.15%
	OTOLARYNGOLOGY	0.14%
	COLORECTAL SURGERY(FORMERLY PROCTOLOGY)	0.14%
	PLASTIC AND RECONSTRUCTIVE SURGERY	0.13%
	OBSTETRICS/GYNECOLOGY	0.10%
	DIAGNOSTIC RADIOLOGY	0.08%
	INTERVENTIONAL PAIN MANAGEMENT	0.08%
	PEDIATRIC MEDICINE	0.07%
	GYNECOLOGY/ONCOLOGY	0.06%
	OSTEOPATHIC MANIPULATIVE THERAPY	0.05%
	PAIN MANAGEMENT	0.04%
	SURGICAL ONCOLOGY	0.04%
	MULTISPECIALTY CLINIC OR GROUP PRACTICE	0.04%
	PERIPHERAL VASCULAR DISEASE	0.03%
	ALLERGY/IMMUNOLOGY	0.03%
	DERMATOLOGY	0.03%
	INTERVENTIONAL RADIOLOGY	0.03%
	NEUROPSYCHIATRY	0.03%
	ADDICTION MEDICINE	0.02%
	PATHOLOGY	0.02%
	OPHTHALMOLOGY	0.02%
	RADIATION ONCOLOGY	0.01%
	PREVENTIVE MEDICINE	0.01%
	NUCLEAR MEDICINE	0.01%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99225 Tracking Number F2 Specialty Society Recommended RVU: **1.39**
Global Period: XXX RUC Recommended RVU: **1.39**

CPT Descriptor: Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: An expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Subsequent observation care of a 23-year-old female with nausea, vomiting, and crampy abdominal pain, who is responding to therapy. Although the patient's condition has improved, there are concerns regarding the abdominal condition requiring continued observation.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work:
Review data not available on the unit (eg, diagnostic and imaging studies). Communicate with other professionals and with patient or patient's family.

Description of Intra-Service Work:
Review medical records and data available on the unit. (Obtain an expanded problem focused interval history.*) (Perform an expanded problem focused interval physical exam.*) (Consider relevant data, options, and risks and formulate/revise diagnosis and treatment plan(s) (straightforward or low complexity medical decision making).*) Discuss diagnosis and treatment options with the patient and/or family. Consider discharge needs of patient. Communicate with other health care professionals. Write/review orders including ordering/arranging for necessary diagnostic testing, consultation and therapeutic intervention(s). Complete medical record documentation. [* Two of these three components are required.]

CPT Code: 99225

Description of Post-Service Work:
Address interval data obtained and changes in condition reported. Communicate results and further care plans to other health care professionals and to the patient and/or family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2009				
Presenter(s):	Scott Manaker, MD, FACP; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS				
Specialty(s):	Internal Medicine (ACP); Surgery (ACS)				
CPT Code:	99225				
Sample Size:	290	**Resp N:**	36	**Response:** 12.4 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**20.00**	85.00	1491.00
Survey RVW:	0.00	1.30	**1.40**	1.85	4.00
Pre-Service Evaluation Time:			**8.50**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	8.00	15.00	**20.00**	25.00	45.00

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

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 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: 2a-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	99225	**Recommended Physician Work RVU: 1.39**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**18.00**	**-8.00**
Pre-Service Positioning Time:		**0.00**	**1.00**	**-1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**6.00**	**-6.00**
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
99232	XXX	1.39	**RUC Time**

CPT Descriptor Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99242	XXX	1.34	**RUC Time**	1,538,957

CPT Descriptor 1 Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92014	XXX	1.42	**RUC Time**	9,987,769

CPT Descriptor 2 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits

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:** 66.6 %

TIME ESTIMATES (Median)	CPT Code: 99225	Key Reference CPT Code: 99232	Source of Time RUC Time
Median Pre-Service Time	10.00	10.00	
Median Intra-Service Time	20.00	20.00	

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**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.96	2.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.92	2.92
Urgency of medical decision making	2.88	2.79
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.48	2.38
Physical effort required	2.25	2.33
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.79	2.71
Outcome depends on the skill and judgment of physician	2.92	2.92
Estimated risk of malpractice suit with poor outcome	2.88	2.71

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.38	2.42
Intra-Service intensity/complexity	2.88	2.75
Post-Service intensity/complexity	2.38	2.38

Additional Rationale and Comments

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

Background

Shifts in practice and payment policy have made it increasingly common for patients to remain in a hospital for several days under observation or outpatient status, instead of being "admitted." This is evidenced by a recent newspaper article: Graham, J. Hospitals' use of 'observation stay' is questioned. Chicago Tribune. March 9, 2009. [http://archives.chicagotribune.com/2009/mar/09/local/chi-observation-caremar09]. Currently, in CPT, there are only codes to report the initial day of observation service and discharge from observation. CPT advice for "subsequent" observation services has directed that code 99499 *Unlisted evaluation and management service* be reported for subsequent days. In response to the increase in the number of observation services that extend beyond the initial observation, the CPT Editorial Panel Executive Committee directed AMA staff to prepare a proposal to request subsequent care observation codes to allow providers to report these services. At the June 2009 CPT meeting, three new codes were approved to report subsequent observation services in a facility.

Survey Data

The American College of Physicians (ACP) and the American College of Surgeons (ACS) conducted a RUC survey for new code 99225. ACP received 20 usable survey responses and ACS received 16 responses. Nearly all of the survey respondents agreed with the typical patient.

			RVW						INTRA					
	CPT	DESC	MIN	25TH	MED	75TH	MAX	PRE	MIN	25TH	MED	75TH	MAX	POST
REF	99232	Subsequent Hosp - Lev 2			1.39			10			20			10
SVY	99225	Subsequent Observ - Lev 2 (n=36)	0.00	1.30	1.40	1.85	4 00	9	8	15	20	25	45	10
	99225	ACS (n=16)	1 30	1.37	1.40	2.00	3.00	9	10	17	20	22	30	10
	99225	ACP (n=20)	0.00	1.19	1.40	1.59	4.00	9	8	12	15	25	45	10

Pre-Service Time:

The Pre-time packages are designed specifically to reflect time required prior to a procedure (in/out of a facility and with/without anesthesia). As a proxy, we recommend Package 2A *Difficult Patient/Straightforward Procedure (No sedation/anesthesia care)* with the following modifications:

- Evaluation: Subtract 10 minutes for H&P which will be performed during the intra-service component. Subtract 3 minutes for setting up the room, checking patient readiness for a procedure, and prepare/review/confirm procedure. Add 4 minutes to communicate with other professionals.
- Positioning: Subtract 1 minute – not required.
- Scrub/Dress/Wait: Subtract 6 minutes – not required

These subtractions and additions result in a pre-time **recommendation of 9 minutes** to review data not available on the unit (eg, diagnostic and imaging studies) and communicate with other professionals and with patient or patient's family. This is one minute less than the pre-time for 99232, but is consistent with the survey data.

Intra-Service Time

The consensus committee reviewing this data believe the physician intra-service time for new code 99225 is equivalent to the time required for 99232. For both codes, the patient will require at least two of the following three activities: An expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity. We **recommend the survey median intra-service time of 20 minutes**, which is the same as the intra-service time for 99232.

Post-Service Time
Similar to our comments above for intra-service time, we believe the post-service time for 99225 would be equivalent to the post-service time for 99232. We **recommend the survey median post-service time of 10 minutes**, which is the ıme as the post-service time for 99232.

RVW Recommendation
We recommend an RVW of 1.39 which is slightly less than the survey median and is the same as the RVW for 99232.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99499 or 99232

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

Specialty internal medicine How often? Commonly

Specialty 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 information is not available and cannot be estimated because of the wide variation in hospital policies regarding patient status designation and third party payer rules.

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. Please see attached table with discussion and estimates.

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? (ie. similar work RVU, and specialty) 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

Attachment: Discussion of Medicare Utilization Estimate

In 2007, there were 477,848 Medicare claims reported for discharge from observation status on a date different than initial date of observation. We estimate that 30% of these patients (143,354) would include an additional day of subsequent" observation (ie, Day 1 = initial observation; Day 2 = subsequent observation; and Day 3 = discharge from observation.)

Further, we estimate that the split between the different levels of subsequent observation services corresponding to the new codes 99224/ - 5 / -6 would be 20% / 60% / 20%. This is similar to the distribution for subsequent hospital visit claims.

99217	Obs Dischrg - diff date	477,848
	30 % =	143,354

		Estimated split of 143,354	
99224	SUB OBS Level 1	28,671	20%
99225	SUB OBS Level 2	86,013	60%
99226	SUB OBS Level 3	28,671	20%

As stated in the additional rationale section of this SoR, CPT advice for "subsequent" observation services has directed that code 99499 *Unlisted evaluation and management service* be reported for subsequent days. Because the utilization for 99499 is only 3642, we believe that some reporting for subsequent observation services may have utilized the subsequent hospital visit codes as representative of the physician work to care for patients in a hospital.

We believe that the physician work (and work RVU) for a patient in a hospital bed is the same regardless of a hospital policy assignment of outpatient or inpatient status. Further, although the payment to the facility may be different, the physician work is the same. Therefore, the estimates for utilization of the new codes would be budget neutral regardless of what percentages are estimated because they most logically represent a shift from 99231-99233 to the corresponding 99224-99226.

We also believe the distribution of utilization for the new codes will not be limited to the specialties surveying the codes (internal medicine and general surgery), but instead will mirror the specialty distribution of the subsequent hospital visit codes (99231-99233). Using the most current year available (2007), we estimate the distribution for 99225 to be:

99225:	INTERNAL MEDICINE	35.63%
	CARDIOLOGY	11.15%
	PULMONARY DISEASE	8.43%
	FAMILY PRACTICE	8.33%
	NEPHROLOGY	6.59%
	INFECTIOUS DISEASE	5.33%
	PHYSICAL MEDICINE AND REHABILITATION	3.44%
	GASTROENTEROLOGY	3.41%
	PSYCHIATRY	3.27%
	NEUROLOGY	2.59%
	HEMATOLOGY/ONCOLOGY	2.18%
	GENERAL SURGERY	1.40%
	ENDOCRINOLOGY	1.05%
	GENERAL PRACTICE	0.88%
	NURSE PRACTITIONERS	0.86%
	CRITICAL CARE (INTENSIVISTS)	0.70%
	MEDICAL ONCOLOGY	0.68%
	EMERGENCY MEDICINE	0.65%
	PHYSICIANS ASSISTANT	0.55%

	UROLOGY	0.50%
	GERIATRIC MEDICINE	0.41%
	ORTHOPEDIC SURGERY	0.19%
	PODIATRY	0.17%
	RHEUMATOLOGY	0.17%
	NEUROSURGERY	0.15%
	HEMATOLOGY	0.12%
	VASCULAR SURGERY	0.12%
	PEDIATRIC MEDICINE	0.11%
	ANESTHESIOLOGY	0.11%
	THORACIC SURGERY	0.09%
	CARDIAC SURGERY	0.07%
	OTOLARYNGOLOGY	0.06%
	OSTEOPATHIC MANIPULATIVE THERAPY	0.06%
	COLORECTAL SURGERY(FORMERLY PROCTOLOGY)	0.06%
	CERTIFIED CLINICAL NURSE SPECIALIST	0.06%
	OBSTETRICS/GYNECOLOGY	0.04%
	INTERVENTIONAL PAIN MANAGEMENT	0.04%
	DIAGNOSTIC RADIOLOGY	0.04%
	PLASTIC AND RECONSTRUCTIVE SURGERY	0.04%
	ALLERGY/IMMUNOLOGY	0.03%
	MULTISPECIALTY CLINIC OR GROUP PRACTICE	0.03%
	PAIN MANAGEMENT	0.03%
	GYNECOLOGY/ONCOLOGY	0.02%
	DERMATOLOGY	0.02%
	ADDICTION MEDICINE	0.02%
	NEUROPSYCHIATRY	0.02%
	SURGICAL ONCOLOGY	0.02%
	NUCLEAR MEDICINE	0.02%
	PERIPHERAL VASCULAR DISEASE	0.01%
	OPHTHALMOLOGY	0.01%
	PREVENTIVE MEDICINE	0.01%
	INTERVENTIONAL RADIOLOGY	0.01%
	PATHOLOGY	0.01%
	RADIATION ONCOLOGY	0.01%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99226 Tracking Number F3 Specialty Society Recommended RVU: **2.00**
Global Period: XXX RUC Recommended RVU: **2.00**

CPT Descriptor: Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least two of these three 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.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Subsequent observation care for a 78-year-old male who fell and suffered contusions to the head and shoulder, but no fractures. He has a history of stroke and is currently on warfarin requiring continued assessment for stability and possible intervention for internal bleeding.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work:
Review data not available on the unit (eg, diagnostic and imaging studies). Communicate with other professionals and with patient or patient's family.

Description of Intra-Service Work:
Review medical records and data available on the unit. (Obtain a detailed interval history.*) (Perform a detailed physical exam.*) (Consider relevant data, options, and risks and formulate/revise diagnosis and treatment plan(s) (high complexity medical decision making).*) Discuss diagnosis and treatment options with the patient and/or family. Consider discharge needs of patient. Communicate with other health care professionals. Write/review orders including ordering/arranging for necessary diagnostic testing, consultation and therapeutic intervention(s). Complete medical record documentation. [* Two of these three components are required.]

Description of Post-Service Work:
Address interval data obtained and changes in condition reported. Communicate results and further care plans to other health care professionals and to the patient and/or family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2009					
Presenter(s):	Scott Manaker, MD, FACP; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS					
Specialty(s):	Internal Medicine (ACP); Surgery (ACS)					
CPT Code:	99226					
Sample Size:	290	**Resp N:**	30	**Response:** 10.3 %		
Sample Type:	Random	**Additional Sample Information:**				
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	2.00	**14.00**	45.00	500.00
Survey RVW:		0.00	1.82	**2.00**	2.65	4.00
Pre-Service Evaluation Time:				**10.00**		
Pre-Service Positioning Time:				**0.00**		
Pre-Service Scrub, Dress, Wait Time:				**0.00**		
Intra-Service Time:		7.00	20.00	**24.00**	30.00	45.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				

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

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2a-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	99226	**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:		**10.00**	**18.00**	**-8.00**
Pre-Service Positioning Time:		**0.00**	**1.00**	**-1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**6.00**	**-6.00**
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? 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
99215	XXX	2.00	**RUC Time**	8,082,829

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99243	XXX	1.88	**RUC Time**	5,025,438

CPT Descriptor 2 Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 63.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 99226**	**Key Reference CPT Code: 99233**	**Source of Time RUC Time**
Median Pre-Service Time	10.00	10.00	

Median Intra-Service Time	30.00	30.00
Median Immediate Post-service Time	15.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	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**	**55.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.89	3.79
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.74	3.74
Urgency of medical decision making	3.74	3.74
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.42	3.26
Physical effort required	2.84	2.89
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.89	3.79
Outcome depends on the skill and judgment of physician	3.79	3.74
Estimated risk of malpractice suit with poor outcome	3.74	3.63

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.89	2.89
Intra-Service intensity/complexity	3.68	3.68
Post-Service intensity/complexity	3.05	3.05

Additional Rationale and Comments

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.*

Background

Shifts in practice and payment policy have made it increasingly common for patients to remain in a hospital for several days under observation or outpatient status, instead of being "admitted." This is evidenced by a recent newspaper article: Graham, J. Hospitals' use of 'observation stay' is questioned. Chicago Tribune. March 9, 2009. [http://archives.chicagotribune.com/2009/mar/09/local/chi-observation-caremar09]. Currently, in CPT, there are only codes to report the initial day of observation service and discharge from observation. CPT advice for "subsequent" observation services has directed that code 99499 *Unlisted evaluation and management service* be reported for subsequent days. In response to the increase in the number of observation services that extend beyond the initial observation, the CPT Editorial Panel Executive Committee directed AMA staff to prepare a proposal to request subsequent care observation codes to allow providers to report these services. At the June 2009 CPT meeting, three new codes were approved to report subsequent observation services in a facility.

Survey Data

The American College of Physicians (ACP) and the American College of Surgeons (ACS) conducted a RUC survey for new code 99226. ACP received 16 survey responses and ACS received 14 responses. Nearly all of the survey respondents agreed with the typical patient.

			RVW						INTRA					
	CPT	DESC	MIN	25TH	MED	75TH	MAX	PRE	MIN	25TH	MED	75TH	MAX	POST
REF	99233	Subsequent Hosp - Lev 3			2.00			10			30			15
SVY	99226	Subsequent Observ - Lev 3 (n=30)	0.00	1.82	2.00	2 65	4.00	10	7	20	24	30	45	15
	99226	ACS (n=16)	1.60	1.98	2.00	3.00	4.00	10	10	22	30	34	45	15
	99226	ACP (n=14)	0.00	1.55	1.90	2.00	4.00	10	7	15	20	24	35	15

Pre-Service Time Recommendation:

The Pre-time packages are designed specifically to reflect time required prior to a procedure (in/out of a facility and with/without anesthesia). As a proxy, we recommend Package 2A *Difficult Patient/Straightforward Procedure (No sedation/anesthesia care)* with the following modifications:

- Evaluation: Subtract 10 minutes for H&P which will be performed during the intra-service component. Subtract 3 minutes for setting up the room, checking patient readiness for a procedure, and prepare/review/confirm procedure. Add 5 minutes to communicate with other professionals.
- Positioning: Subtract 1 minute – not required.
- Scrub/Dress/Wait: Subtract 6 minutes – not required

These subtractions and additions result in a pre-time **recommendation of 10 minutes** to review data not available on the unit (eg, diagnostic and imaging studies) and communicate with other professionals and with patient or patient's family. This is the same pre-time for 99232

Intra-Service Time Recommendation:

The consensus committee reviewing this data believe the physician intra-service time for new code 99226 is equivalent to the time required for 99233. For both codes, the patient will require at least two of the following three activities: A detailed interval history; a detailed examination; medical decision making of high complexity. We note that there will be extreme variability in the type of patient, including co-morbidities not identified. The typical patient utilized for the

survey was based on a patient that both internal medicine and general surgery could survey. Therefore, **we are recommending the 75th percentile time of 30 minutes,** which is the same as the intra-service time for 99233.

Post-Service Time Recommendation:

We believe the post-service time for 99226 would be equivalent to the post-service time for 99233. We **recommend the survey median post-service time of 15 minutes**, which is the same as the post-service time for 99233.

RVW Recommendation

We recommend the median RVW of 2.00 which is the same as the RVW for 99226.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99499 or 99233

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

Specialty internal medicine How often? Commonly

Specialty 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 information is not available and cannot be estimated because of the wide variation in hospital policies regarding patient status designation and third party payer rules.

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. Please see attached table with discussion and estimates.

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? (ie. similar work RVU, and specialty) 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

Attachment: Discussion of Medicare Utilization Estimate

In 2007, there were 477,848 Medicare claims reported for discharge from observation status on a date different than initial date of observation. We estimate that 30% of these patients (143,354) would include an additional day of subsequent" observation (ie, Day 1 = initial observation; Day 2 = subsequent observation; and Day 3 = discharge from observation.)

Further, we estimate that the split between the different levels of subsequent observation services corresponding to the new codes 99224/ - 5 / -6 would be 20% / 60% / 20%. This is similar to the distribution for subsequent hospital visit claims.

99217	Obs Dischrg - diff date	477,848
	30 % =	143,354

		Estimated split of 143,354	
99224	SUB OBS Level 1	28,671	20%
99225	SUB OBS Level 2	86,013	60%
99226	SUB OBS Level 3	28,671	20%

As stated in the additional rationale section of this SoR, CPT advice for "subsequent" observation services has directed that code 99499 *Unlisted evaluation and management service* be reported for subsequent days. Because the utilization for 99499 is only 3642, we believe that some reporting for subsequent observation services may have utilized the subsequent hospital visit codes as representative of the physician work to care for patients in a hospital.

We believe that the physician work (and work RVU) for a patient in a hospital bed is the same regardless of a hospital policy assignment of outpatient or inpatient status. Further, although the payment to the facility may be different, the physician work is the same. Therefore, the estimates for utilization of the new codes would be budget neutral egardless of what percentages are estimated because they most logically represent a shift from 99231-99233 to the orresponding 99224-99226.

We also believe the distribution of utilization for the new codes will not be limited to the specialties surveying the codes (internal medicine and general surgery), but instead will mirror the specialty distribution of the subsequent hospital visit codes (99231-99233). Using the most current year available (2007), we estimate the distribution for 99226 to be:

99226:	INTERNAL MEDICINE	37.75%
	PULMONARY DISEASE	12.97%
	CARDIOLOGY	10.52%
	FAMILY PRACTICE	6.45%
	NEPHROLOGY	5.83%
	INFECTIOUS DISEASE	4.57%
	PSYCHIATRY	3.16%
	HEMATOLOGY/ONCOLOGY	2.85%
	NEUROLOGY	2.69%
	GASTROENTEROLOGY	1.88%
	CRITICAL CARE (INTENSIVISTS)	1.68%
	PHYSICAL MEDICINE AND REHABILITATION	1.60%
	GENERAL SURGERY	1.37%
	MEDICAL ONCOLOGY	0.90%
	GENERAL PRACTICE	0.87%
	EMERGENCY MEDICINE	0.67%
	ENDOCRINOLOGY	0.66%
	NURSE PRACTITIONERS	0.55%
	GERIATRIC MEDICINE	0.45%

	PHYSICIANS ASSISTANT	0.33%
	UROLOGY	0.30%
	HEMATOLOGY	0.23%
	ANESTHESIOLOGY	0.23%
	NEUROSURGERY	0.16%
	ORTHOPEDIC SURGERY	0.15%
	RHEUMATOLOGY	0.13%
	PEDIATRIC MEDICINE	0.11%
	THORACIC SURGERY	0.11%
	VASCULAR SURGERY	0.11%
	CARDIAC SURGERY	0.09%
	PODIATRY	0.09%
	OTOLARYNGOLOGY	0.06%
	OSTEOPATHIC MANIPULATIVE THERAPY	0.05%
	OBSTETRICS/GYNECOLOGY	0.05%
	COLORECTAL SURGERY(FORMERLY PROCTOLOGY)	0.04%
	INTERVENTIONAL PAIN MANAGEMENT	0.04%
	DIAGNOSTIC RADIOLOGY	0.04%
	MULTISPECIALTY CLINIC OR GROUP PRACTICE	0.03%
	GYNECOLOGY/ONCOLOGY	0.03%
	CERTIFIED CLINICAL NURSE SPECIALIST	0.02%
	PLASTIC AND RECONSTRUCTIVE SURGERY	0.02%
	PREVENTIVE MEDICINE	0.02%
	ALLERGY/IMMUNOLOGY	0.02%
	PAIN MANAGEMENT	0.02%
	SURGICAL ONCOLOGY	0.02%
	OPHTHALMOLOGY	0.02%
	DERMATOLOGY	0.02%
	NEUROPSYCHIATRY	0.01%
	UNKNOWN PHYSICIAN SPECIALTY	0.01%
	PERIPHERAL VASCULAR DISEASE	0.01%
	RADIATION ONCOLOGY	0.01%
	HAND SURGERY	0.01%
	ADDICTION MEDICINE	0.01%
	NUCLEAR MEDICINE	0.01%
	INTERVENTIONAL RADIOLOGY	0 01%

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

CPT Long Descriptors:

F1	**99224** Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend XX minutes at the bedside and on the patient's hospital floor or unit.
F2	**99225** Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend XX minutes at the bedside and on the patient's hospital floor or unit.
F3	**99226** Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed 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 XX minutes at the bedside and on the patient's hospital floor or unit.

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 the surveying specialties. Similar to other facility-only E/M services (eg, 99231-99233), we recommend no non-facility direct inputs.

Pre-, Intra-, Post-Service Clinical Labor Activities:

Zero labor

Supplies:

Zero supplies

Equipment:

Zero equipment

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

CPT Long Descriptor:

F1	**99224** Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend XX minutes at the bedside and on the patient's hospital floor or unit.
F2	**99225** Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend XX minutes at the bedside and on the patient's hospital floor or unit.
F3	**99226** Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed 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 XX minutes at the bedside and on the patient's hospital floor or unit.

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 facility practice expense details were discussed by a consensus committee of the surveying specialties. Similar to other facility-only E/M services (eg, 99231-99233), we recommend no facility direct inputs.

Pre-, Intra-, Post-Service Clinical Labor Activities:

Zero labor

Supplies:

Zero supplies

Equipment:

Zero equipment

	A	B	C	D	E	F	G	H	I
1	AMA Specialty Society RVS Update Committee Recommendation			F1		F2		F3	
2				99224		99225		99226	
3	**Meeting Date: October 2009**			Subsequent observation services Level 1		Subsequent observation services Level 2		Subsequent observation services Level 3	
4	LOCATION	Code	Staff Type	Office	Facility	Office	Facility	Office	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	0	n/a	0	n/a	0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	0	n/a	0	n/a	0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	0	n/a	0	n/a	0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	0	n/a	0	n/a	0
10	PRE-SERVICE								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		0		0		0
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA		0		0		0
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA		0		0		0
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		0		0		0
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		0		0		0
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		0		0		0
41	**End: Patient leaves office**								
42	POST-SERVICE Period								
43	**Start: Patient leaves office/facility**								
53	*Total Office Visit Time*	L037D	RN/LPN/MTA	0	0	0	0	0	0
54	**End: with last office visit before end of global period**								
55	MEDICAL SUPPLIES	Code	Unit						
56					0		0		0
57	Equipment	Code							
58					0		0		0

603

AMA/Specialty Society RVS Update Committee/Health Care Professionals Advisory Committee
Summary of Recommendations
Originated from the Five-Year Review – Site of Service Anomaly Screen

February and April 2010

Excision and Debridement

CPT Codes 11043 and 11044 were identified by the RUC's Five Year Review Identification Workgroup through the Site of Service Anomaly Screen in September 2007. The specialty recommended and the RUC agreed that codes 11043 and 11044, along with family codes 11040-11042, should be reviewed by CPT because they may describe work that is too variable (ie, bi-modal). These codes were included with many other codes under review by the CPT Excision and Debridement Workgroup.

11010 Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues

11011 skin, subcutaneous tissue, muscle fascia, and muscle

11012 skin, subcutaneous tissue, muscle fascia, muscle, and bone

CPT codes 11010, 11011 and 11012 were revised at the October 2009 CPT Editorial Panel meeting to state, "Debridement including removal of foreign material at the site of an open fracture~~(s)~~ and/or an open dislocation~~(s)~~ (eg, excisional debridement);" The intent of this revision was to clarify to payors and providers that these codes describe debridement of a single traumatic wound caused by an open fracture which creates a single exposure, despite the number of fractures or dislocations in the same anatomic site. The CPT Editorial Panel and the RUC representative at that meeting were unsure if these changes were editorial and therefore requested further information from the specialty societies who perform these services. The specialties indicated that the intra-service work descriptors and the typical patient vignette used for all three codes when these codes were surveyed in 1996 are all quite specific that the typical patient and work involved are for a single traumatic wound from a single bon exposure. The typical patient vignette as societies who perform these services indicated that the original valuation of this service from a survey conducted in 1996 was based on a single fracture as clearly stated in their vignettes. **Based on this rationale, the RUC agreed with the specialty society that the revisions made to these descriptors were editorial and the current work RVUs for these services correctly relate to the typical patient and should be maintained.**

11042 Debridement subcutaneous tissue (includes epidermis and dermis, if performed); first 20 square centimeters or less

CPT Code 11042 was revised by the CPT Editorial Panel to Debridement subcutaneous tissue (includes epidermis and dermis, if performed); first 20 square centimeters or less ~~skin, and subcutaneous tissue~~. The RUC reviewed the recommended work RVU for this service, 1.12 Work RVUs, and noted that it is higher than the current value for this service. The RUC reviewed the compelling evidence provided by the specialty that this service was originally surveyed by podiatry only and while they represent the dominant providers of the service (40%), general surgery (18%) was not represented in the 2005 survey of this service. Additionally, the RUC reviewed the RBRVS history of this code, including the fact that Harvard surveyed plastic surgeons (who represent a small fraction of the utilization); and that Harvard surveyed the codes with a 10-day global and then CMS (then HCFA) subsequently over several years reduced the work RVUs and changed the global period through the refinement process. The RUC agreed that there was compelling evidence to consider a new work RVU for this service.

The RUC reviewed the survey data for 11042 and made slight modifications to the pre-service time adjusting it to 11 minutes and agreed that 15 minutes of intra-service time and 10 minutes of post-service time were representative of the service. The specialty societies agreed that the survey median of 1.30 work RVUs was not an appropriate value for this service based on comparisons of time and intensity to the key reference code 16020 *Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)* (Work RVU=0.80). The specialty societies agreed that an appropriate recommendation would be to reaffirm the previous RUC HCPAC recommendation for this code, 1.12 work RVUs, as valued during the 2005 Five-Year Review. The RUC agreed that this was an appropriate valuation as it maintains relativity between the reference code and the surveyed code as the surveyed code has more intra-service time as compared to the reference code (15 minutes and 10 minutes, respectively). Further, the surveyed code requires more psychological stress, physical effort and mental effort and judgment to perform than the reference code. An additional reference code that the RUC agreed validated this recommended work RVU is MPC code 56605 *Biopsy of vulva or perineum (separate procedure); 1 lesion* (Work RVU=1.10) as this reference code requires a similar amount of work to perform and has the same intra-service time, 15 minutes. **Based on these comparisons, the RUC recommends 1.12 Work RVUs for 11042.**

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

Based on the compelling evidence discussed and accepted by the RUC for code 11042, the RUC agreed that the work RVUs for 11045 did not require work neutrality. The specialties estimated that 20% of wounds reported with 11042 will be large enough or extensive enough (ie, trauma) to report one or more units of 11045. The specialty societies agreed that to appropriately value this service, the

relativity of the survey data collected between 11042 and 11045 should be maintained. The recommended work RVU for 11042 (1.12 Work RVUs) was 14% less than the survey median work RVU (1.30 Work RVUs). Therefore, the specialty societies will maintain the percent difference by applying a 14 percent reduction to the median work value of 11045 (0.80 Work RVUs) resulting in a recommendation of 0.69 work RVUs for 11045. This value is further supported by reference code 36575 *Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site* (Work RVU=0.67) as this service and the surveyed code have similar work RVUs and the same intra-service time, 15 minutes. **Based on these comparisons, the RUC recommends 0.69 Work RVUs for 11045.**

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

In February 2010, the specialty societies surveyed 11043 and 11044 and found considerable disagreement with the survey vignettes and the new global period (090 days), along with wide variation in surveyed facility length of stay. Per the CPT revised introduction, these debridements may be reported for injuries, infections, wounds, or chronic ulcers. Although the breadth and depth of the debridement for each of these conditions may be similar, the pre-work and especially the post-work will be considerably different and widely variable. Additionally, the patient will be widely variable. The specialties recommended and the RUC agreed to request that CMS change the global period to 000. CMS agreed and codes 11043 and 11044 were re-surveyed as 000-day global codes.

607

Based on the compelling evidence discussed and accepted by the RUC for code 11042 as well as the change in global period, the RUC agreed that the work RVU for 11043 did not require work neutrality. At the April 2010 RUC meeting, the RUC reviewed the survey data from 54 general surgeons and podiatrists and compared the surveyed code to the key reference code 15002 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children* (Work RVU=3.65). The RUC noted that the reference code had significantly more total service time as compared to the surveyed code, 115 minutes and 86 minutes respectively. Further, the RUC noted that the surveyed code was a less intense service to perform in comparison to the reference code. The RUC, based on this comparison, agreed that 3.00 Work RVUs, the survey 25th percentile, accurately reflects the relative physician work to perform this service. **The RUC recommends 3.00 Work RVUs for 11043.**

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

Based on the compelling evidence discussed and accepted by the RUC for code 11042, the RUC agreed that the work RVU for 11046 did not require work neutrality. The RUC assessed the survey results from 30 general surgeons. The RUC reviewed the specialty's recommended service times and agreed that because this service has a ZZZ global period, that the post-service time should be reduced from 5 minutes to 1 minute to account for additional monitoring for infection; additional discussion about ongoing care with facility staff and patient/family; and additional application of dressings/padding. This reduction to the immediate post-service time also makes this service consistent with other ZZZ global codes which have very minimal or no pre and post service times associated with them. The RUC compared the surveyed code to the key reference code 15005 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children* (Work RVU=1.60). The RUC noted that with the change in post-service time for the surveyed code, both 11046 and 15005 require the same amount of time to perform, 21 minutes. However, the RUC noted that the reference code requires greater technical skill, physical effort and psychological stress to perform in comparison to the surveyed code because of the surgical site, eg, face, eyelids, mouth and/or genitalia. Based on this comparison, the RUC agreed that 1.29 RVUs, the survey's 25th percentile, accurately reflects the relative physician work to perform this service. **The RUC recommends 1.29 Work RVUs for 11046.**

809

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

In February 2010, the specialty societies surveyed 11043 and 11044 and found considerable disagreement with the survey vignettes and the new global period (090 days), along with wide variation in surveyed facility length of stay. Per the CPT revised introduction, these debridements may be reported for injuries, infections, wounds, or chronic ulcers. Although the breadth and depth of the debridement for each of these conditions may be similar, the pre-work and especially the post-work will be considerably different and widely variable. Additionally, the patient will be widely variable. The specialties recommended and the RUC agreed to request that CMS change the global period to 000. CMS agreed and codes 11043 and 11044 were re-surveyed as 000-day global codes.

Based on the compelling evidence discussed and accepted by the RUC for code 11042 as well as the change in global period, the RUC agreed that the work RVU for 11044 did not require work neutrality. At the April 2010 meeting, the RUC reviewed the survey data from 48 general surgeons and podiatrists and compared the surveyed code to the reference code 15004 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children* (Work RVU=4.58). The RUC noted that the reference code had the same intra-service time, 45 minutes. Further, the RUC noted that the surveyed code and the reference code required similar mental effort and judgment to

perform. The RUC, based on this comparison, agreed that 4.56 Work RVUs, the survey 25th percentile, accurately reflects the relative physician work to perform this service and maintains proper rank order with 11042 and 11043. **The RUC recommends 4.56 Work RVUs for 11044.**

11047 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 square centimeters, or part thereof

Based on the compelling evidence discussed and accepted by the RUC for code 11042, the RUC agreed that the work RVU for 11047 did not require work neutrality. The RUC reviewed the survey data from 30 general surgeons. The RUC agreed with the specialty's recommended service times as this service has a ZZZ global period, the post-service time should be reduced from 5 minutes to 1 minute to account for the additional monitoring time for infection, additional application of dressing/padding and additional discussion about ongoing care with facility staff as well as to make consistent with other ZZZ global codes which have very minimal or no pre and post service times associated with them. The RUC compared the surveyed code to the reference code 15005 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children* (Work RVU=1.60). The RUC noted that the surveyed code has more intra-service time as compared to the reference code, 30 minutes and 20 minutes, respectively. Further, the RUC noted that the surveyed code requires greater mental effort and judgment, psychological stress as well as overall is a more intense procedure to perform in comparison to the reference code. Based on this comparison, the RUC agreed that 2.00 work RVUs, the survey's median, accurately reflects the relative physician work to perform this service. **The RUC recommends 2.00 Work RVUs for 11047.**

609

Practice Expense

The RUC reviewed and accepted the direct practice expense inputs for 11042-11047 in the non-facility and facility settings.

CPT Code (•New)	Track-ing Num-ber	CPT Descriptor	Global Period	Work RVU Recommendation
Wound debridements (11042-11047) are reported by depth of tissue that is removed and by surface area of the wound. These services may be reported for injuries, infections, wounds and chronic ulcers. When performing debridement of a single wound, report depth using the deepest level of tissue removed. In multiple wounds, sum the surface area of those wounds that are at the same depth, but do not combine sums from different				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
depths. For example: When bone is debrided from a 4 sq cm heel ulcer and from a 10 sq cm ischial ulcer, report the work with a single code, 11044. When subcutaneous tissue is debrided from a 16 sq cm dehisced abdominal wound and a 10 sq cm thigh wound, report the work with 11042 for the first 20 sq cm and 11045 for the second 6 sq cm. If all four wounds were debrided on the same day, use modifier 59 with 11042 and 11045 and 11044. *For dermabrasions, see 15780-15783)(For nail debridement, see 11720-11721)(For burn(s), see 16000-16035)*(For pressure ulcers, see 15920-15999)				
▲11010	G1	Debridement including removal of foreign material ~~associated with an~~ at the site of an open fracture~~(s)~~ and/or an open dislocation~~(s)~~ (eg, excisional debridement); skin and subcutaneous tissues	010	4.19 (No Change – RUC Recommendation)
▲11011	G2	skin, subcutaneous tissue, muscle fascia, and muscle	000	4.94 (No Change – RUC Recommendation)
▲11012	G3	skin, subcutaneous tissue, muscle fascia, muscle, and bone	000	6.87 (No Change – RUC Recommendation)
D 11040		~~Debridement; skin, partial thickness~~	000	N/A
D 11041		~~skin, full thickness~~ (11040, 11041 have been deleted) (For debridement of skin, ie, epidermis and/or dermis only, see 97597 and 97598) (For active wound care management, see 97597-97598) (For debridement of burn wounds, see 16020-16030)	000	N/A

610

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲11042	G4	Debridement,~~; skin, and~~ subcutaneous tissue (includes epidermis and dermis, if performed); first 20 square centimeters or less (For debridement of skin [ie, epidermis and/or dermis only], see 97597, 97598)	000	1.12 (RUC Recommendation)
#+•11045	G5	each additional 20 square centimeters, or part thereof (List separately in addition to code for primary procedure) (Use 11045 in conjunction with 11042)	ZZZ	0.69 (RUC Recommendation)
▲11043	G6	Debridement, ~~skin, subcutaneous tissue, and~~ muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 square centimeters or less	~~010~~ 000	3.00 (RUC Recommendation)
#+•11046	G7	each additional 20 square centimeters, or part thereof (List separately in addition to code for primary procedure) (Use 11046 in conjunction with 11043)	ZZZ	1.29 (RUC Recommendation)
▲11044	G8	Debridement, ~~skin, subcutaneous tissue, muscle, and~~ bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 square centimeters or less	~~010~~ 000	4.56 (RUC Recommendation)
#+•11047	G9	each additional 20 square centimeters, or part thereof (List separately in addition to code for primary procedure)	ZZZ	2.00 (RUC Recommendation)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(Use 11047 in conjunction with 11044) (Do not report 11042-11047 in conjunction with 97597-97602 for the same wound)		

Repair (Closure)

Use the codes in this section to designate wound closure utilizing sutures, staples, or tissue adhesives (eg, 2-cyanoacrylate), either singly or in combination with each other, or in combination with adhesive strips. Wound closure utilizing adhesive strips as the sole repair material should be coded using the appropriate E/M code.

Definitions

The repair of wounds may be classified as Simple, Intermediate, or Complex.

Simple repair *is used when the wound is superficial; eg, involving primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, and requires simple one layer closure. This includes local anesthesia and chemical or electrocauterization of wounds not closed.*

Intermediate repair *includes the repair of wounds that, in addition to the above, require layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure. Single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair.*

Complex repair includes the repair of wounds requiring more than layered closure, viz., scar revision, debridement (eg, traumatic lacerations or avulsions), extensive undermining, stents or retention sutures. Necessary preparation includes creation of a limited defect for repairs ~~(eg, excision of a scar requiring a complex repair)~~ or the debridement of complicated lacerations or avulsions. Complex repair does not include excision of benign (11400-11446) or malignant (11600-11646) lesions, excisional preparation of a wound bed (15002-15005) or debridement of an open fracture or open dislocation.

612

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

Instructions for listing services at time of wound repair:

1. *The repaired wound(s) should be measured and recorded in centimeters, whether curved, angular, or stellate.*

2. *When multiple wounds are repaired, add together the lengths of those in the same classification (see above) and from all anatomic sites that are grouped together into the same code descriptor. For example, add together the lengths of intermediate repairs to the trunk and extremities. Do not add lengths of repairs from different groupings of anatomic sites (eg, face and extremities). Also, do not add together lengths of different classifications (eg, intermediate and complex repairs).*

   When more than one classification of wounds is repaired, list the more complicated as the primary procedure and the less complicated as the secondary procedure, using modifier 51.

3. Decontamination and/or debridement: Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure. ~~(For extensive debridement of soft tissue and/or bone, see 11040-11044.)~~

   (For extensive debridement of soft tissue and/or bone, not associated with open fracture(s) and/or dislocation(s) resulting from penetrating and/or blunt trauma, see ~~11040-11044~~ 11042-11047.)

   (For extensive debridement of subcutaneous tissue, muscle fascia, muscle, and/or bone associated with open fracture(s) and/or dislocation(s), see 11010-11012.)

4. Involvement of nerves, blood vessels and tendons: Report under appropriate system (Nervous, Cardiovascular, Musculoskeletal) for repair of these structures. The repair of these associated wounds is included in the primary procedure unless it qualifies as a complex repair ~~wound~~, in which case modifier 51 applies.

   Simple ligation of vessels in an open wound is considered as part of any wound closure.

   Simple "exploration" of nerves, blood vessels or tendons exposed in an open wound is also considered part of the essential treatment of the wound and is not a separate procedure unless appreciable dissection is required. If the wound requires enlargement, extension of dissection (to determine penetration), debridement, removal of foreign body(s), ligation or coagulation of minor subcutaneous and/or muscular blood

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

vessel(s) of the subcutaneous tissue, muscle fascia, and/or muscle, not requiring thoracotomy or laparotomy, use codes 20100-20103, as appropriate.

Skin Replacement Surgery and Skin Substitutes

~~Identify by size and location of the defect (recipient area) and the type of graft or skin substitute; includes simple debridement of granulation tissue or recent avulsion.~~

~~When a primary procedure such as orbitectomy, radical mastectomy, or deep tumor removal requires skin graft for definitive closure, see appropriate anatomical subsection for primary procedure and this section for skin graft or skin substitute.~~

~~Use codes 15002-15005 for initial wound recipient site preparation.~~

~~Use codes 15100-15261 for autologous skin grafts. For autologous tissue-cultured epidermal grafts, use codes 15150-15157. For harvesting of autologous keratinocytes and dermal tissue for tissue-cultured skin grafts, use code 15040. Procedures are coded by recipient site. Use codes 15170-15176 for acellular dermal replacement~~.

Repair of donor site requiring skin graft or local flaps is to be added as an additional procedure.

Surgical preparation

Codes 15002-15005 describe ~~burn and wound preparation or incisional or excisional release of scar contracture resulting in an open wound requiring a skin graft.~~ the services related to preparing a clean and viable wound surface for placement of a graft, flap, skin replacement, skin substitute or negative pressure wound therapy. In some cases closure may be possible using adjacent tissue transfer (14000-14061) or complex repair (13100-13153). In all cases appreciable nonviable tissue is removed to treat a burn, traumatic wound or a necrotizing infection. The clean wound bed may also be created by incisional release of a scar contracture resulting in a surface defect from separation of tissues. The intent is to heal the wound by primary intention, or by the use of negative pressure wound therapy. Patient conditions may require the closure or application of graft, flap, skin replacement or skin substitute to be delayed, but in all cases the intent is to include these treatments or negative pressure wound therapy to heal the wound. Do not report 15002-15005 for removal of nonviable tissue/debris in a chronic wound (eg venous or diabetic) when the wound is left to heal by secondary intention. See active wound management codes (97597-97598) and debridement codes (11042-11047), for this

614

CPT Code (•New)	Track-ing Num-ber	CPT Descriptor	Global Period	Work RVU Recommendation

service. For necrotizing soft tissue infections in specific locations, see 11004-11008.

When a primary procedure such as orbitectomy, radical mastectomy, or deep tumor removal requires skin graft for definitive closure, see appropriate anatomical subsection for primary procedure and this section for skin graft or skin substitute.

Select the appropriate code from 15002-15005 based upon location and size of the resultant defect. Use code 15002 or 15004, as appropriate, for excisions and incisional releases resulting in wounds up to and including 100 sq. cm of surface area. Use 15003 or 15005 for each additional 100sq. cm or part thereof. Report complex repairs, adjacent tissue transfer, flaps and grafts separately. Report the application of the skin substitute codes 15100-15431 separately. Do not report 15002-15005 in conjunction with 15340-15341

Application of skin replacements and skin substitutes

615

Codes 15100-15431 describe the application of skin replacements and skin substitutes. Select the code based upon the type of skin replacement or skin substitute. The following definition should be applied to those codes that reference "100 sq cm or 1% of body area of infants and children" when determining the involvement of body size: The measurement of 100 sq cm is applicable to adults and children age 10 and older; percentages of body surface area apply to infants and children younger than the age of 10. When square centimeters are indicated, this refers to 1 sq cm up to the stated amount. Add-on codes begin with the next sq cm (eg, 130 sq cm would be coded using a code for the first 100 sq cm and an add-on code for the next 30 sq cm).The measurements apply to the size of the recipient area.

These codes are not intended to be reported for simple graft application alone or application stabilized with dressings (eg, by simple gauze wrap). The skin substitute/graft is anchored using the surgeon's choice of fixation. When services are performed in the office, the supply of the skin substitute/graft should be reported separately. Routine dressing supplies are not reported separately. ~~When square centimeters are indicated, this refers to 1 sq cm up to the stated amount. Add-on codes begin with the next sq cm (eg, 130 sq cm would be coded using a code for the first 100 sq cm and an add-on code for the next 30 sq cm).~~ Application includes simple debridement of granulation tissue or recent avulsion. Use modifier 58 for staged application procedure(s). ~~(For microvascular flaps, see 15756-15758)~~

Surgical Preparation

(15000, 15001 have been deleted. To report, see 15002-15005)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
15002		Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children (For linear scar revision, see 13100-13153)	000	3.65 (No Change)
+15003		each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure) (Use 15003 in conjunction with 15002)	ZZZ	0.80 (No Change)
15004		Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children	000	4.58 (No Change)
+15005		each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure) (Use 15005 in conjunction with 15004) ~~(Report 15002-15005 in conjunction with code for appropriate skin grafts or replacements [15050-15261, 15330-15336]. List the graft or replacement separately by its procedure number when the graft, immediate or delayed, is~~	ZZZ	1.60 (No Change)

616

CPT Code (•New)	Track-ing Num-ber	CPT Descriptor	Global Period	Work RVU Recommendation
		~~applied)~~ ~~(For excision of benign lesions, see 11400-11471)~~ ~~(For excision of malignant lesions, see 11600-11646)~~ ~~(For excision to prepare or create recipient site with dressings or materials not listed in 15040-15431, use 15002-15005 only)~~ ~~(For excision with immediate skin grafting, use 15002-15005 in conjunction with 15050-15261)~~ ~~(For excision with immediate allograft skin placement, use 15002-15005 in conjunction with 15300-15336 and 15360-15366)~~ ~~(For excision with immediate xenogeneic dermis placement, use 15002-15005 in conjunction with 15400-15421~~)		
Medicine **Physical Medicine and Rehabilitation** **Active Wound Care Management** *Active wound care procedures are performed to remove devitalized and/or necrotic tissue and promote healing. Provider is required to have direct (one-on-one) patient contact.* (Do not report 97597-97602 in conjunction with ~~11040-11044~~ 11042-11047 for the same wound) (For debridement of burn wounds, see 16020-16030)				
▲97597	G10	Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), ~~Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without~~	~~XXX~~ 000	0.54 (HCPAC Recommendation)

617

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, ~~may include use of a whirlpool,~~ per session, total wound(s) surface area; ~~than or equal to~~ first 20 square centimeters or less		
+▲97598	G11	~~total wound(s) surface area greater than~~ each additional 20 square centimeters, or part thereof (List separately in addition to code for primary procedure) (Use 97598 in conjunction with 97597)	~~XXX~~ ZZZ	0.40 (HCPAC Recommendation)

618

November 24, 2009

Barbara Levy, MD
Chair, AMA/Multi-specialty Relative Value Update (RUC) Committee
American Medical Association
515 N. State St.
Chicago, IL 60610

Re: CPT codes 11010-11012

Dear Dr. Levy,

CPT Codes 11010, 11011, and 11012 were revised at the October 2009 CPT Editorial Panel meeting as part of the excision/debridement workgroup. The changes for each of the three codes were the same - the codes were revised to read ***"Debridement including removal of foreign material associated with open fracture~~(s)~~ and/or dislocation~~(s)~~"***. This change was made to clarify that the codes are intended to describe debridement of a single traumatic wound caused by an open fracture. In the original descriptor, it is our opinion that the parenthetical (s) was referring to fractures or dislocations in the same anatomical area, but with a single traumatic wound. When the excision/debridement workgroup began reviewing the codes, we recommended these changes to avoid any confusion by payors and providers. We also wanted to have consistency with the work descriptors (see below), which clearly specified a single wound.

It is the consensus opinion of the orthopaedic RUC advisors that this represents an editorial change. The codes, which have been RUC surveyed, should not require a new survey. We believe the current values are correct and appropriate for the revised descriptor. Accordingly, we request that the RUC remove the codes from the October 2009 CPT new codes Level of Interest (LOI) form and redefine the code changes as editorial only. We are comfortable surveying these codes for the April 2010 RUC meeting should the RUC recommend it, however, we believe a survey would simply confirm the current values as appropriate and as such, the time and cost of the survey could be avoided by defining the changes as editorial only.

The intra-service work descriptors used for the codes in the 1996 survey are all quite specific that the typical patient and the work are for a single traumatic wound with a corresponding single surgical exposure. Below is the current typical patient vignette intra-service work descriptor for CPT code 11010 (underlines added).[1]

> **Typical Patient Vignette:** A 28-year-old male falls from a ladder and sustains an open tibial and fibular fracture with foreign material contamination of the skin subcutaneous tissues, necessitating debridement.
>
> **Work Descriptor:** The wound is inspected and cultures may be taken. A tentative plan is made regarding the type of closure or coverage which will be required and subsequent debridement decisions are made with that plan in mind. The open area of skin is inspected and crushed or devitalized skin is sharply débrided, attempting to be conservative and retain whatever skin is viable and useful for coverage. The wound is irrigated with sterile fluid, often containing antibiotics, with a power, pulsatile lavage

[1] The Vignettes and intra-work descriptors for 11011 and 11012 are exactly the same as 11010 only with the additional wording regarding muscle fascia, muscle and bone added based on the respective descriptors.

system. Foreign material in the subcutaneous tissue is meticulously removed by sharp debridement, or by picking it out with forceps, which can be a tedious and time-consuming task if the material consists of small bits of grit or dirt. The wound may be carefully extended proximally and distally to allow better access to deeper structures, with thought given to incision placement so as not to compromise later flaps. Muscle fascia, nerves and vessels are inspected. The bone ends are exposed and cleaned with adequate irrigation. Hemostasis is obtained. When the wound is judged to be adequately cleaned and débrided, a decision must be made as to how the wound will be dressed, and how the eventual closure or coverage will be accomplished. This requires significant experience and judgment to choose a plan which will avoid infection and minimize disability. Once an appropriate technique is chosen, dressing are applied. This may entail partial wound closure, use of drains, use of rubber bands or special devices to maintain skin position, or special dressing material. Splints may by applied.

It is our opinion that the existing values are based on a single wound, and the changes to 11010, 11011 and 11012 act only to conform to the vignettes and work descriptors.

The typical patient vignette refers to an open tibia and fibula fracture, and the use of the singular for fracture is intentional and anatomically correct. This is because the fibula bone in the leg is often referred to as an atavistic bone.[2] When the tibia is fractured, the fibula often breaks concomitantly. As such, when the typical patient vignette refers to two bones, only one, the tibia, is typically associated with the open traumatic wound, because the fibula is better protected by the surrounding soft tissues.

We believe the survey respondents would interpret the vignettes no differently than they did for the previous RUC survey; the result would be redundant information, with the same times and values. The additional expense for conducting the survey would be overly burdensome. We ask the RUC to reconsider the determination that these three codes are non-editorial.

Thank you for your attention to this matter.

Sincerely,

William Creevy, MD AAOS RUC Advisor	Tye Ouzounian, MD AOFAS RUC Advisor
Daniel Nagle, MD ASSH RUC Advisor	Brian Parsley, MD AAHKS RUC Advisor

Cc: Sherry Smith, Director AMA, Physician Payment Policy and Systems
RUC Research Subcommittee

[2] By this we mean that the fibula has regressed in importance during human evolution as we transitioned from arboreal quadrupeds to bipedal upright locomotion. The fibular diaphysis (shaft) is a much smaller bone than the tibia and no longer contributes to prehension since the human leg and foot has evolved differently than our simian relatives. Given its lessor importance in locomotion and skeletal support, the fibular diaphysis has become much smaller in size than the tibia.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11042 Tracking Number G4 Specialty Society Recommended RVU: **1.12**
Global Period: 000 RUC Recommended RVU: **1.12**

CPT Descriptor: Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 square centimeters or less

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old male with insulin dependent diabetes presents with a 4.0 cm x 3.5 cm x 0.8 cm non-infected ulceration involving the skin and subcutaneous tissue of the plantar lateral aspect of the right heel. The decision is made to debride the wound.

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

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

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

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work:
Review labs and/or imaging studies, if available. Meet with patient/family to review the benefits, risks and alternatives to debridement. An updated medication history is obtained, including aspirin, vitamin E, and/or other blood thinners along with a review of pertinent medical problems that may have arisen since the previous visit. The planned procedure is explained and the healing period with restrictions is reviewed. Review and have patient sign informed consent. Assist with patient positioning in a supine and slightly lateral position, with the leg bumped up 30 degrees and stabilized. The existing dressings are removed. An appropriate physical examination is performed to include the vascular and neurological status of the lower extremity(-ies). The wound and surrounding skin is prepped and draped. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work:
Inspect and document the ulceration for size, location, depth; classification/staging; and any interval changes, if appropriate, from any previous inspections. Anesthesia, if necessary, is utilized. The ulcer bed is debrided with forceps, scalpel, scissors or tissue nippers excising the necrotic skin, if present, and subcutaneous tissues to the level of viable tissue. The wound is irrigated and hemostasis is obtained. Upon completion, the ulcer is re-measured and the size recorded.

Description of Post-Service Work:
Apply an appropriate surgical dressing based upon the amount of exudate present at the time of debridement. Provide for a moist healing environment to help assist with subsequent wound healing and granulation tissue formation. Determine type of padding and specific material needed to offload the ulcer area; cut pad to properly remove pressure; apply padding. Instruct patient and/or care giver on appropriate home care; discuss future management of the condition; instruct on prop selection and sizing of footwear; instruct on importance of controlling concomitant medical conditions; dictate operativ report; complete medical record; communicate with primary care physician. Arrange follow-up care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS; Frank Spinosa, DPM; Timothy Tillo, DPM				
pecialty(s):	general surgery, podiatry				
CPT Code:	11042				
Sample Size:	200	**Resp N:**	33	**Response:** 16.5 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	28.00	**60.00**	100.00	300.00
Survey RVW:	0.78	0.90	**1.30**	2.00	5.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	7.00	10.00	**15.00**	20.00	30.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
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: 1a-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	11042	**Recommended Physician Work RVU: 1.12**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**9.00**	**13.00**	**-4.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**1.00**	**6.00**	**-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**
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
16020	000	0.80	**RUC Time**

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

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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**	2,455,457

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
99213	XXX	0.97	**RUC Time**	102,084,135

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers c agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, th presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
16025	000	1.85	**RUC Time**

CPT Descriptor Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)

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

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 27.2 %

TIME ESTIMATES (Median)	**CPT Code: 11042**	**Key Reference CPT Code: 16020**	**Source of Time RUC Time**
Median Pre-Service Time	11.00	20.00	
Median Intra-Service Time	15.00	10.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	

Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	**36.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.00	1.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.11	2.00
Urgency of medical decision making	2.56	2.33
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.44	2.67
Physical effort required	2.33	2.22
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.67	2.22
Outcome depends on the skill and judgment of physician	2.67	2.56
Estimated risk of malpractice suit with poor outcome	2.89	2.56

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.33	2.11
Intra-Service intensity/complexity	2.44	2.56
Post-Service intensity/complexity	2.00	1.78

Additional Rationale and Comments

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

Background – Harvard & CMS

The history of 11042 began in June 1991, when CMS proposed that the code have a 10-day global and an RVW of 2.85. However, later that year (and before publication of the 1992 PFS), the CMDs met and changed the RVW to 1.27 ...intending to also change the global period. However, the published global period did not change to 0-day until the 1993 PFS, when CMS further reduced the RVW (to 1.14). Budget neutrality adjustments over time resulted in an RVW of 1.12.

In 2005, CMS requested the RUC to review code 11042 for the third 5YR. CPT 11042 was surveyed by podiatry and reviewed by the HCPAC. This procedure, however, is typically performed by non-HCPAC providers. The HCPAC reviewed the APMA recommendation and agreed with APMA that there was compelling evidence due to a flawed methodology used in the previous Harvard valuation for 11042. The HCPAC, however, did not agree to increase the RVW for the procedure and recommended maintaining RVW of 1.12. The HCPAC did adjust the pre-times for evaluation, positioning, and scrub/dress/wait from 7/2/2 to 9/1/1. This occurred before the development of pre-time packages.

In the June 2006 NPRM, CMS disagreed and reduced the RVW with the following rationale: The survey times all reflect significant reductions from current Harvard-based times used to value these services. Based on this comparison which shows decreases in time ranging from 47 percent to 68 percent, we believe that the low value from the survey more accurately represents the valuation. CMS assigned an RVW of 0.80 for 11042, which was the lowest survey estimation.

CMS did not offer any comparison codes and ignored the reference codes that the HCPAC used to review 11042. Clearly from the discussion above, the Harvard review prior to 1991 and subsequent CMD global period changes and reductions in 1992 and 1993 resulted in an RVW for 11042 based on CMD estimation without regard to time or visit data. Additionally, we note that 11042 was reviewed by plastic surgery in the Harvard study, a specialty that represent only a fraction of the utilization of the code.

Background – CPT & RUC

In September 2007, the RUC 5YR ID WG identified codes with a site of service anomaly. Code 11042 was added to the list as part of a family of debridement codes, even though the code did not have an anomaly (ie, 0-day global). Further review of the family of codes resulted in the CPT Excision and Debridement Workgroup. In 2009, the WG recommendations to delete codes 11040 and 11041 and revise the introductory text and the descriptors for codes 11042, 11043, and 11044 was approved by the CPT Editorial Panel. The changes reflect other integumentary code descriptors that are based on size.

Compelling Evidence

The ACS and APMA conducted a joint survey of 11042. General surgery and podiatry represent approximately 60% of the Medicare utilization of current code 11042. While this is a majority of providers, we note that there are many other significant providers, including primary care specialties. We also note a multi-modal distribution in site of service. These points are made to emphasize that the current global 0-day global period is most accurate for 11042 because the patient, wound, and provider are widely variable with widely variable post-service work.

The joint specialty expert panel reviewed the history of 11042 and believe there is significant compelling evidence that the current RVW for 11042 is based on a flawed process:

1. Harvard data indicates plastic surgeons reviewed 11042 even though they represent a fraction of the utilization.
2. Harvard data indicates 11042 was reviewed as a 10-day global procedure.
3. The RVW and global period were refined by CMDs several times: Jun-91 RVW=3.33 glob=10; Nov-91 RVW=1.27 glob=10; Nov-92 RVW=1.14 glob=0. No rationale was provided in any Rule. Each changed was published as Final.
4. The RVW was reduced in 2007 (to 0.80 RVWs) by CMS to the lowest estimated RVW from a survey by podiatry (not the only nor typical provider). The justification for the reduction was a comparison to Harvard

data, which we have shown above to be flawed. Additionally, there was no relative comparison to other 0-day global codes to support the CMS reduction – using magnitude estimation and relativity.

Recommendation

're-time package 1A is recommended with an additional 2 minutes for positioning (to equal 3 minutes) and 1 minute ,ess for scrub, dress, wait per the survey median. This procedure is typically performed in a facility setting and will represent many presentations requiring various positions from supine to prone. The recommendation of 3 minutes is extremely conservative. Additionally, we note that a significant number of patients will also have comorbidities and/or be trauma-related and would be considered "difficult." Therefore the choice of package 1A is also conservative (ie, straightforward patient).

The joint specialty expert panel **recommends the survey median RVW of 1.30**. The resulting IWPUT is 0.045 which is less than the intensity of 99202 and 99213, codes with the same intra-service time, but less pre-/post-work. Further, 11042 is typically a facility-based procedure compared with the key reference code 16020 or MPC code 11100 that have similar intra-time, but are typically performed in an office and require much less pre-/post-time. The low intensity of 0.045 and the additional pre- and post-work compared to references justify an RVW of 1.30.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11042

How often do physicians 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

'pecialty podiatry How often? Commonly

Specialty How often?

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

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. estimate 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? 1,171,278 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2008 Medicare utilization = 1,171,278

Specialty general surgery	Frequency 222500	Percentage 18.99 %	
Specialty podiatry	Frequency 454200	Percentage 38.77 %	
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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 15361

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:11045 Tracking Number G5 Specialty Society Recommended RVU: **0.69**
Global Period: ZZZ RUC Recommended RVU: **0.69**

CPT Descriptor: Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 square centimeters, or part thereof (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 82-year-old male presents with a non-healing abdominal wound. The original surgical procedure was an exploratory laparotomy. The wound is 9 cm x 4 cm x 3.5 cm and has granulation tissue along the side walls of the wound, but dry fatty tissue in the base of the wound. After review, a decision is made to perform a debridement. [NOTE: 11045 is an ADD-ON code. You are being asked to consider ONLY additional work AFTER debridement of the first 20 sq cm when responding to this survey.]

Percentage of Survey Respondents who found Vignette to be Typical: 78%

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

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

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

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

Moderate Sedation

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

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

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

Description of Pre-Service Work: N/A

Description of Intra-Service Work:
Intra-service work includes additional assessment and debridement after the first 20 sq cm. This may include: additional dressing removal after induction of anesthesia; additional sharp debridement with additional excision of devitalized, traumatized, nonviable, infected or colonized subcutaneous tissue (including epidermis and dermis, as necessary) to obtain clean viable wound edges; additional irrigation; additional hemostasis; and additional dressing and padding.

Note: If multiple separate site (additive) wounds are involved (eg, trauma), additional and separate documentation for size, location, depth, classification/staging, and ongoing treatment plan will be required, along with additional prep/drape.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010		
Presenter(s):	Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS		
Specialty(s):	surgery		
CPT Code:	11045		
Sample Size:	150	**Resp N:** 32	**Response:** 21.3 %
Sample Type:	Random **Additional Sample Information:** Surveys were completed by ACS Fellows who indicated the following specialties: general surgery, plastic surgery, vascular surgery, orthopaedic surgery, trauma, and pediatric surgery		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	6.00	**11.00**	50.00	250.00
Survey RVW:	0.50	0.80	**0.80**	1.23	2.50
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	7.00	10.00	**15.00**	20.00	30.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
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: ZZZ Global Code

CPT Code:	11045	**Recommended Physician Work RVU: 0.69**		
		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? 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
15003	ZZZ	0.80	**RUC Time**

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

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99213	XXX	0.97	**RUC Time**	104,454,972

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	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:** 62.5 %

TIME ESTIMATES (Median)	CPT Code: 11045	Key Reference CPT Code: 15003	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	15.00	
Median Immediate Post-service Time	0.00	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	**15.00**	**16.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	1.65	1.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.75	1.68
Urgency of medical decision making	1.70	1.74
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.05	1.89
Physical effort required	1.84	1.95
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	1.75	1.74
Outcome depends on the skill and judgment of physician	2.35	2.21
Estimated risk of malpractice suit with poor outcome	2.15	2.05

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	1.60	1.59
Intra-Service intensity/complexity	1.80	2.00
Post-Service intensity/complexity	1.35	1.41

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.*

Review of excision and debridement codes by the CPT Excision and Debridement Workgroup resulted in the recommendation to delete codes 11040 and 11041; revise the introductory text and the descriptors for codes 11042, 11043, and 11044; and create three new add-on codes to report debridement of each additional 20 sq cm of subcutaneous tissue (11045), muscle/fascia (11046), and bone (11047).

The American College of Surgeons conducted a RUC survey for new code 11045 and received 32 responses. After reviewing the data, the College recommends the survey median RVW of 0.80 for 11045. This is the same RVW as the reference code 15003, which has the same intra-time and requires similar work. Both procedures would typically be performed in a facility setting. The resulting intensity (0.053) is the same as MPC code 99213, which has the same intra-service time. The recommended RVW of 0.80 is less than 99213 to account for the difference in pre/post work. Based on the rationale presented in the SoR for 11042, we do not believe that the RVW for 11045 requires work neutrality consideration.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This is an add-on code that is paired with 11042.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11042

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

Specialty all surgeons How often? Commonly

pecialty 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. estimate 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? 265,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimatation is based on percentage of current frequency for 11042 that may be larger than 20 sq cm.

Specialty all surgeons	Frequency 187400	Percentage 70.71	%
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? (ie. similar work RVU, and specialty) 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:11043 Tracking Number G6 Specialty Society Recommended RVU: **3.00**
Global Period: 000 RUC Recommended RVU: **3.00**

CPT Descriptor: Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 square centimeters or less

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74-year-old diabetic female with limited mobility presents with a 4.0 cm x 3.5 cm posterior heel ulceration involving the skin and subcutaneous tissues and Achilles tendon/muscle. She requires debridement of the wound, including debridement of the tendon/muscle.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 11%

Is moderate 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: Review labs and/or imaging studies, if available. Meet with patient/family to review the benefits, risks and alternatives to debridement. Update H&P. The planned procedure is explained and the healing period with restrictions is reviewed. Review and have patient sign informed consent. The existing dressings are removed. An appropriate physical examination is performed to include the vascular and neurological status of the lower extremity(-ies). Monitor/assist with patient positioning; padding of bony prominences. 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. The leg is prepped and draped. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Inspect and document the ulceration for size, location, depth; classification/staging; and any interval changes, if appropriate, from any previous inspections. Anesthesia, as necessary, is utilized. The posterior heel ulcer bed is debrided, excising non viable skin and subcutaneous, if present, and tendon/muscle tissues with forceps, scissors, scalpel and tissue nippers to the level of viable tissue. Hemostasis is obtained. The wound is inspected and irrigated. Upon completion, the ulcer is re-measured and the size recorded.

Description of Post-Service Work: Apply an appropriate surgical dressing based upon the amount of exudate present at the time of debridement. Provide for a moist healing environment to help assist with subsequent wound healing and granulation tissue formation. Determine type of padding and specific material needed to offload the ulcer area; cut pad to

properly remove pressure. Apply padding. Instruct patient and/or care giver on appropriate home care (ie, activity, bathing). Discuss future management of the condition. Instruct on proper selection and sizing of footwear. Order physical therapy for the uses of crutches or walker if necessary. Instruct on importance of controlling concomitant medical conditions. Dictate 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.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS; Timothy Tillo, DPM; Seth Rubenstein, DPM				
pecialty(s):	general surgery, podiatry				
CPT Code:	11043				
Sample Size:	300	**Resp N:**	54	**Response:** 18.0 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	7.00	**15.00**	34.00	500.00
Survey RVW:	2.00	3.00	**3.65**	4.50	6.50
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	10.00	21.00	**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**
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: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	11043	**Recommended Physician Work RVU: 3.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**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? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
15002	000	3.65	**RUC Time**

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

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99204	XXX	2.43	**RUC Time**	3,312,933

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordinatio

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19103	000	3.69	**RUC Time**	101,909

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

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:** 33.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 11043**	**Key Reference CPT Code:** 15002	**Source of Time** **RUC Time**
Median Pre-Service Time	41.00	75.00	
Median Intra-Service Time	30.00	20.00	
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	**86.00**	**115.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.94	2.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.06	3.00
Urgency of medical decision making	3.05	3.39
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.28	3.22
Physical effort required	3.22	3.17
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.33	3.33
Outcome depends on the skill and judgment of physician	3.61	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	2.83	2.78
Intra-Service intensity/complexity	3.11	3.17
Post-Service intensity/complexity	2.67	2.67

Additional Rationale and Comments

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

Background – Harvard & CMS

The history of 11043 and 11044 begins with the Harvard review of intra-time only with extrapolation of pre- and post-time and visits – for a 90-day global period. In the June 1991 NPRM, CMS proposed an RVW of 6.84 for 11043 and 7.97 for 11044. However, later that year (and before publication of the 1992 PFS), the CMDs met and reduced the RVW for both codes (to 2.12 and 2.61) ...intending to also change the global period. However, the published global period did not change to 10-days until the 1993 PFS, when CMS further reduced the RVWs for both codes (to 1.87 and 2.34). A previous CMS (then HCFA) Medical Officer has confirmed that during these changes, no consideration was given to the time or visits for these codes – just to reductions per CMD estimates for refinement.

Background – CPT & RUC

The Harvard 90-day global intra-time and estimated pre/post work was maintained in a database until the first 5YR when the AAOS surveyed these codes using vignettes for patients with open fracture wounds. At the time, the RUC rejected the AAOS RVW recommendations and directed the AAOS to CPT to obtain new codes. The times and visits from the failed AAOS surveys were entered into the RUC database and maintained for the past 15 years - with the asterisked sentence "Surveyed physician time has not been validated by the RUC."

In September 2007, the RUC 5YR ID WG identified 11043 and 11044 through a site of service screen. Further review of the family of codes resulted in the CPT Excision and Debridement Workgroup. In 2009, the WG recommendations to delete codes 11040 and 11041 and revise the introductory text and the descriptors for codes 11042, 11043, and 11044 was approved by the CPT Editorial Panel. The changes reflect other integumentary code descriptors that are based on size. Further, CMS changed the global period for these to codes from 10-days to 90-days – back to the global period from the Harvard study which was rejected by the CMDs in 1991.

At the February 2010 RUC meeting, the ACS and APMA presented survey data for 11043 and 11044 and indicated there was considerable disagreement with the survey vignettes and the new global period, along with wide variation in surveyed facility LOS. The two open fracture wound debridement codes 11011-12 correspond to breadth and depth of 11043-44, however, these open fracture debridement codes have a 0-day global period. The ACS and APMA expressed concern about the assigned 90-day global which did not fit the widely variable patient profile possibilities. The Medicare data for site of service are variable and multi-modal (CPT 11043: 20% office; 28% outpt; 20% inpt. CPT 11044: 14% office; 33% outpt; 33% inpt). The data for provider specialty is also variable and multi-modal (CPT 11043: GS 24%; DPM 21%; IM/NP 20%. CPT 11044: GS 35%; DPM 19%; ORT 13%).

Because there truly is no "typical" patient, the ACS and APMA recommended that the RUC request that CMS assign a 0-day global period to codes 11043 and 11044. CMS agreed with a 0-day global assignment for codes 11043 and 11044.

Recommendation - 11043

The American College of Surgeons and American Podiatric Medical Association conducted a RUC survey for 11043 as a 0-day global code and received 54 responses. Podiatry (n=17) median RVW was 4.25 and median intra-time was 25 minutes. Surgery (general, vascular, trauma, orthopaedic) (n=37) median RVW was 3.65 and median intra-time was 30 minutes. The consensus panel reviewing the survey data agree that the combined survey median of 30 minutes accurately represents the intra-service time.

Although the median intra-time for 11043 is greater than the reference code 15002, the consensus panel does not believe the total work is the same. Therefore, we are **recommending the survey 25th percentile RVW of 3.00**. This value is less than key reference code 15002 and reflects the lower intensity of 11043. The recommendation of 3.00 also places 11043 in correct relative rank order compared with 11042 (RUC recommendation 1.12). Code 11043 typically requires twice as much intra-time and additional pre/post time in a facility setting with sedation in comparison with 11042.

In support of the recommendation, we reviewed two MPC codes that require the same intra-time and have slightly less and greater RVWs – 99204 (2.43) and 19103 (3.69). The recommendation of the 25th pctl RVW of 3.00 falls midway between the RVWs for these two MPC codes. The intensity of 0.061 for 11043 is less than the intensity for both 99204 and 19103.

Pre-time package 2B* is selected as typical, with the addition of 2 minutes for positioning and padding to allow surgical access to the heel for the 30 minute 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) 11043

How often do physicians 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 podiatry How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. estimate 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? 167,757 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2008 frequency

Specialty general surgery Frequency 40900 Percentage 24.38 %

Specialty podiatry Frequency 35600 Percentage 21.22 %

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 20900 has the same RVW and same intra-time and is familiar to podiatrists who participated in the survey

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:11046 Tracking Number G7 Specialty Society Recommended RVU: **1.29**
Global Period: ZZZ RUC Recommended RVU: **1.29**

CPT Descriptor: Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 square centimeters, or part thereof (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old paraplegic male presents with a non-healing pressure ulcer. After a fall 5 years ago, the patient suffered a spinal cord injury at T10. This stage 3 full thickness pressure ulcer is located over the right ischial tuberosity and measures 5.5 cm x 6 cm x 4.5 cm. Despite the use of seat cushions and local dressings, the wound has actually increased in size over time. After review, a decision is made to perform a debridement. [NOTE: 11046 is an ADD-ON code. You are being asked to consider ONLY additional work AFTER debridement of the first 20 sq cm when responding to this survey.]

Percentage of Survey Respondents who found Vignette to be Typical: 57%

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

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

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

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

Moderate Sedation

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

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

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

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Description of Pre-Service Work: N/A

Description of Intra-Service Work:
Intra-service work includes additional assessment and debridement after the first 20 sq cm. This may include: additional dressing removal after induction of anesthesia; additional sharp debridement with additional excision of devitalized, traumatized, nonviable, infected or colonized muscle and/or fascia (including epidermis, dermis, and subcutaneous tissue, as necessary) to obtain clean viable wound edges; additional irrigation; additional hemostasis; and additional dressing and padding.

Note: If multiple separate site (additive) wounds are involved (eg, trauma), additional and separate documentation for size, location, depth, classification/staging, and ongoing treatment plan will be required, along with additional prep/drape.

Description of Post-Service Work:
Large and/or multiple wounds with exposed muscle and/or fascia will require additional monitoring for infection; additonal discussion about ongoing care with facility staff and patient/family; and additional application of dressings/padding.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010		
Presenter(s):	Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS		
Specialty(s):	surgery		
CPT Code:	11046		
Sample Size:	150	**Resp N:** 30	**Response:** 20.0 %
Sample Type:	Random **Additional Sample Information:** Surveys were completed by Fellows of the American College of Surgeons who indicated the following specialties: general surgery, plastic surgery, vascular surgery, orthopaedic surgery, trauma, and pediatric surgery		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	4.00	**10.00**	25.00	200.00
Survey RVW:	0.70	1.29	**1.50**	2.00	3.20
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	15.00	**20.00**	20.00	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: ZZZ Global Code

CPT Code:	11046	**Recommended Physician Work RVU: 1.29**		
		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:		**20.00**		

Immediate Post Service-Time:	**1.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
15005	ZZZ	1.60	**RUC Time**

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

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
99213	XXX	0.97	**RUC Time**	102,084,136

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13122	ZZZ	1.44	**RUC Time**	13,137

CPT Descriptor 2 Repair, complex, scalp, arms, and/or legs; 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: 12 **% of respondents:** 40.0 %

TIME ESTIMATES (Median)	**CPT Code: 11046**	**Key Reference CPT Code: 15005**	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	20.00	
Median Immediate Post-service Time	1.00	1.00	

Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	**21.00**	**21.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.40	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.10	2.70
Urgency of medical decision making	3.10	2.90
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	3.10
Physical effort required	2.70	2.80
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.30	3.30
Outcome depends on the skill and judgment of physician	3.40	3.70
Estimated risk of malpractice suit with poor outcome	3.40	3.30

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.64	2.70
Intra-Service intensity/complexity	2.91	2.80
Post-Service intensity/complexity	2.36	2.40

Additional Rationale and Comments

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

Review of excision and debridement codes by the CPT Excision and Debridement Workgroup resulted in the recommendation to delete codes 11040 and 11041; revise the introductory text and the descriptors for codes 11042, 11043, and 11044; and create three new add-on codes to report debridement of each additional 20 sq cm of subcutaneous tissue (11045), muscle/fascia (11046), and bone (11047).

The American College of Surgeons conducted a RUC survey for new code 11046 and received 30 responses. After reviewing the data, the College recommends the survey 25th percentile RVW of 1.29 for 11046. This is less than the RVW of the reference code 15005. Although both 1046X and 15005 require the same intra-time, excision of the tissues involved in 15005 would be more complex because of the location - face, eyelids, mouth, neck, etc. In support of the recommendation, we reviewed two MPC codes that require slightly less and more intra-time and have slightly less and greater RVWs – 99213 and 13122. The recommendation of the 25th pctl RVW of 1.29 falls midway between the RVWs for these two MPC codes. This value results in an intensity of 0.059, which is appropriately greater than 11045 (0.053, per RUC recommendation) and between 99213 (0.053) and 13122 (0.063). We are also recommending 5 minutes of post-service time. As described above, large and/or multiple wounds with exposed muscle and/or fascia will require additional monitoring for infection; additional discussion about ongoing care with facility staff and patient/family; and additional application of dressings/padding. Further, based on the background discussion presented in the SoR for 11043 as compelling evidence, we do not believe that the RVW for 11046 requires work neutrality consideration.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This is an add-on code that is paired with 11043.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11043

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

Specialty surgeons	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. estimate 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? 38,702 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimatation is based on percentage of current frequency for 11043 that may be larger than 20 sq cm. (see table below). We note the Medicare frequency decreased significantly from 2006-2008, so this may be an over-estimate.

Specialty surgeons Frequency 36236 Percentage 93.63 %

Specialty nonsurgeons Frequency 2466 Percentage 6.37 %

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 15361

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

Medicare Frequency Estimate

38,702	**11046X**	**surg**	**ADDITIVE**			**36,236**	94%	**11046X**	**non-surg**	**ADDITIVE**			**2,466**	6%
	167,757	24%	20%	x	1	8,052		167,757	21%	5%	x	1	1,761	
	167,757	24%	20%	x	2	16,105		167,757	21%	1%	x	2	705	
	167,757	24%	10%	x	3	12,079		167,757	21%	0%	x	3	-	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11044 Tracking Number G8 Specialty Society Recommended RVU: **4.56**
Global Period: 000 RUC Recommended RVU: **4.56**

CPT Descriptor: Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 square centimeters or less

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old diabetic male with limited mobility presents with a 4.0 cm x 3.5 cm posterior heel ulceration involving the skin and subcutaneous tissues, Achilles tendon/muscle, and calcaneus. He requires debridement of the wound, including debridement of the tendon/muscle and calcaneus.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 10%

Is moderate 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: Review labs and/or imaging studies, if available. Meet with patient/family to review the benefits, risks and alternatives to debridement. Update H&P. The planned procedure is explained and the healing period with restrictions is reviewed. Review and have patient sign informed consent. The existing dressings are removed. An appropriate physical examination is performed to include the vascular and neurological status of the lower extremity(-ies). Monitor/assist with patient positioning; padding of bony prominences. 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. The foot is prepped and draped. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: Inspect and palpate the surrounding skin, wound edge, and exposed soft tissue and bone. Document the size, location, drainage, and depth of the wound. Inspect for and document sinus tracts, undermining, odor, and the quality of the wound bed tissue. Anesthesia, as necessary, is utilized. Remove, with scalpel and forceps, scissors, ronjeur, or tissue nippers, the overhanging skin at the wound margins and the non-viable fatty tissue and the exposed bone using the ronjeur cutting it back to bleeding bone and deeper than the soft tissue. Send samples of the debrided bone for culture and/or histopathology. Copiously irrigate the wound bed. Ensure hemostasis of the wound bed.

Description of Post-Service Work: Apply an appropriate surgical dressing based upon the amount of exudate present at the time of debridement. Provide for a moist healing environment to help assist with subsequent wound healing and

granulation tissue formation. Determine type of padding and specific material needed to offload the ulcer area; cut pad to properly remove pressure. Apply padding. Determine if systemic antibiotic therapy is to be initiated empirically or deferred pending the results of the culture. Instruct patient and/or care giver on appropriate home care (ie, activity, bathing). Discuss future management of the condition. Instruct on proper selection and sizing of footwear. Order physical therapy for the uses of crutches or walker if necessary. Instruct on importance of controlling concomitant medic conditions. Dictate operative report. Procedure note is written in the patient chart. All appropriate medical records ar completed, including discharge summary and discharge instructions, and insurance forms.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010		
Presenter(s):	Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS; Timothy Tillo, DPM; Seth Rubenstein, DPM		
Specialty(s):	general surgery, podiatry		
CPT Code:	11044		
Sample Size:	300	**Resp N:** 48	**Response:** 16.0 %
Sample Type:	Random	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	5.00	**8.00**	15.00	100.00
Survey RVW:	3.60	4.56	**5.00**	5.42	7.00
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	25.00	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:	**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: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	11044	**Recommended Physician Work RVU: 4.56**		
		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:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**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
15004	000	4.58	**RUC Time**

CPT Descriptor Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
45380	000	4.43	**RUC Time**	801,741

CPT Descriptor 1 Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	000	6.74	**RUC Time**	33,834

CPT Descriptor 2 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral

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:** 50.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 11044**	**Key Reference CPT Code:** 15004	**Source of Time** RUC Time
Median Pre-Service Time	51.00	75.00	
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	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**116.00**	**150.00**	

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.54	3.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.50
Urgency of medical decision making	3.67	3.36
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.67	3.55
Physical effort required	3.46	3.32
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.71	3.55
Outcome depends on the skill and judgment of physician	3.83	3.73
Estimated risk of malpractice suit with poor outcome	3.71	3.36

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.63	3.27
Intra-Service intensity/complexity	3.75	3.45
Post-Service intensity/complexity	3.29	3.18

Additional Rationale and Comments

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 Recommendations for the appropriate formula and format.*

Background – Harvard & CMS

The history of 11043 and 11044 begins with the Harvard review of intra-time only with extrapolation of pre- and post-time and visits – for a 90-day global period. In the June 1991 NPRM, CMS proposed an RVW of 6.84 for 11043 and 7.97 for 11044. However, later that year (and before publication of the 1992 PFS), the CMDs met and reduced the RVW for both codes (to 2.12 and 2.61) ...intending to also change the global period. However, the published global period did not change to 10-days until the 1993 PFS, when CMS further reduced the RVWs for both codes (to 1.87 and 2.34). A previous CMS (then HCFA) Medical Officer has confirmed that during these changes, no consideration was given to the time or visits for these codes – just to reductions per CMD estimates for refinement.

Background – CPT & RUC

The Harvard 90-day global intra-time and estimated pre/post work was maintained in a database until the first 5YR when the AAOS surveyed these codes using vignettes for patients with open fracture wounds. At the time, the RUC rejected the AAOS RVW recommendations and directed the AAOS to CPT to obtain new codes. The times and visits from the failed AAOS surveys were entered into the RUC database and maintained for the past 15 years - with the asterisked sentence "Surveyed physician time has not been validated by the RUC."

In September 2007, the RUC 5YR ID WG identified 11043 and 11044 through a site of service screen. Further review of the family of codes resulted in the CPT Excision and Debridement Workgroup. In 2009, the WG recommendations to delete codes 11040 and 11041 and revise the introductory text and the descriptors for codes 11042, 11043, and 11044 was approved by the CPT Editorial Panel. The changes reflect other integumentary code descriptors that are based on size. Further, CMS changed the global period for these to codes from 10-days to 90-days – back to the global period from the Harvard study which was rejected by the CMDs in 1991.

At the February 2010 RUC meeting, the ACS and APMA presented survey data for 11043 and 11044 and indicated there was considerable disagreement with the survey vignettes and the new global period, along with wide variation in surveyed facility LOS. The two open fracture wound debridement codes 11011-12 correspond to breadth and depth of 11043-44, however, these open fracture debridement codes have a 0-day global period. The ACS and APMA expressed concern about the assigned 90-day global which did not fit the widely variable patient profile possibilities. The Medicare data for site of service are variable and multi-modal (CPT 11043: 20% office; 28% outpt; 20% inpt. CPT 11044: 14% office; 33% outpt; 33% inpt). The data for provider specialty is also variable and multi-modal (CPT 11043: GS 24%; DPM 21%; IM/NP 20%. CPT 11044: GS 35%; DPM 19%; ORT 13%).

Because there truly is no "typical" patient, the ACS and APMA recommended that the RUC request that CMS assign a 0-day global period to codes 11043 and 11044. CMS agreed with a 0-day global assignment for codes 11043 and 11044.

Recommendation - 11044

The American College of Surgeons and American Podiatric Medical Association conducted a RUC survey for 11044 as a 0-day global code and received 48 responses. Podiatry (n=13) median RVW was 5.10 and median intra-time was 40 minutes. Surgery (general, vascular, trauma, orthopaedic) (n=35) median RVW was 5.00 and median intra-time was 45 minutes. The consensus panel reviewing the survey data agree that the combined survey median of 45 minutes accurately represents the intra-service time.

The consensus panel believes the total work for 11044 and key reference code 15004 is the same and **recommend the survey 25th percentile RVW of 4.56**. The recommendation of 4.56 also places 11044 in correct relative rank order compared with 11042 (RUC recommendation 1.12) and 11043 (current recommendation 3.00). Code 11044 typically requires three times as much intra-time and additional pre/post time in a facility setting under anesthesia in comparison with 11042 and 50 percent more time than 11043.

In support of the recommendation, we reviewed two MPC codes. Code 11044 and MPC code 45380 (RVW=4.43) have similar total times, but some of the intra-time for 45380 reflects administration of moderate/light sedation, which has a lower intensity than the procedure itself. Therefore the recommended RVW of 4.56 for 11044 (0.071) relates well to 45380 (IWPUT=0.057). The recommendation of 4.56 is also appropriate less than MPC code 34812 which has the same intra-time, but is significantly 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: No

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11044

How often do physicians 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 podiatry How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. estimate 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? 53,021 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2008 frequency

Specialty general surgery Frequency 17709 Percentage 33.39 %

Specialty podiatry Frequency 10600 Percentage 19.99 %

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? (ie. similar work RVU, and specialty) 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:11047 Tracking Number G9 Specialty Society Recommended RVU: **2.00**
Global Period: ZZZ RUC Recommended RVU: **2.00**

CPT Descriptor: Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 square centimeters, or part thereof (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 34-year-old paraplegic male presents with a stage 4 sacral decubitus ulcer. The eschar has been debrided, but the sacral bone is exposed, bleeds, and he has an elevated temperature. There is serous drainage from the ulcer base. The ulcer measures 6.5 cm x 6.0 cm x 4.5 cm. After review, a decision is made to perform a debridement of the bone. [NOTE: 11047 is an ADD-ON code. You are being asked to consider ONLY additional work AFTER debridement of the first 20 sq cm when responding to this survey.]

Percentage of Survey Respondents who found Vignette to be Typical: 61%

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

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

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

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

Moderate Sedation

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

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

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

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Description of Pre-Service Work: N/A

Description of Intra-Service Work:
Intra-service work includes additional assessment and debridement after the first 20 sq cm. This may include: additional dressing removal after induction of anesthesia; additional sharp debridement with additional excision of devitalized, traumatized, nonviable, infected or colonized bone (including epidermis, dermis, subcutaneous tissue, muscle and/or fascia, as necessary) to obtain clean viable wound edges; additional irrigation; additional hemostasis; and additional dressing and padding.

Note: If multiple separate site (additive) wounds are involved (eg, trauma), additional and separate documentation for size, ocation, depth, classification/staging, and ongoing treatment plan will be required, along with additional prep/drape.

Description of Post-Service Work:
Large and/or multiple wounds with exposed bone will require additional monitoring for infection; additonal discussion about ongoing care with facility staff and patient/family; and additional application of dressing/padding.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010		
Presenter(s):	Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS		
Specialty(s):	surgery		
CPT Code:	11047		
Sample Size:	150	**Resp N:** 30	**Response:** 20.0 %
Sample Type:	Random **Additional Sample Information:** Surveys were completed by Fellows of the American College of Surgeons who indicated the following specialties: general surgery, plastic surgery, vascular surgery, orthopaedic surgery, trauma, and pediatric surgery		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**4.00**	10.00	200.00
Survey RVW:	1.20	1.70	**2.00**	2.50	5.50
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	25.00	**30.00**	35.00	50.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
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: ZZZ Global Code

CPT Code:	11047	**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:		**30.00**		

Immediate Post Service-Time:	**1.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
15005	ZZZ	1.60	**RUC Time**

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

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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**	10,081

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
3122	ZZZ	1.44	**RUC Time**	13137

CPT Descriptor 2 Repair, complex, scalp, arms, and/or legs; 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: 12 **% of respondents:** 40.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 11047**	**Key Reference CPT Code: 15005**	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	20.00	
Median Immediate Post-service Time	1.00	1.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	**31.00**	**21.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.42
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	3.17
Urgency of medical decision making	3.33	3.25
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	3.00
Physical effort required	2.92	2.92
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.83	3.75
Outcome depends on the skill and judgment of physician	3.42	3.50
Estimated risk of malpractice suit with poor outcome	3.50	3.17

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.17	3.00
Intra-Service intensity/complexity	3.58	3.33
Post-Service intensity/complexity	2.67	2.58

Additional Rationale and Comments

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

Review of excision and debridement codes by the CPT Excision and Debridement Workgroup resulted in the recommendation to delete codes 11040 and 11041; revise the introductory text and the descriptors for codes 11042, 11043, and 11044; and create three new add-on codes to report debridement of each additional 20 sq cm of subcutaneous tissue (11045), muscle/fascia (11046), and bone (11047).

The American College of Surgeons conducted a RUC survey for new code 11047 and received 30 responses. After reviewing the data, the College recommends the survey median RVW of 2.00 for 11047. This is greater than the RVW of the reference code 15005 and accounts for one-third more intra-time. This value results in an intensity (0.063) that is less than the reference code (0.079) which is more complex because of the location - face, eyelids, mouth, neck, etc, Both procedures would typically be performed in a facility setting. In support of the recommendation, we reviewed the data for MPC code 13133 which has the same intra-time, but a higher RVW; and MPC code 13122 which requires 20% less intra-time and is typically performed in an office setting. The recommendation of the median RVW of 2.00 falls between the RVWs for these two MPC codes. This value results in an intensity of 0.063, which is appropriately greater than 11045X (0.053, per RUC recommendation) and 11046 (0.059, per current recommendation), the same as 13122 (0.063), and less than 13133 (0.073). We are also recommending 5 minutes of post-service time. As described above, large and/or multiple wounds with exposed bone will require additional monitoring for infection; additional discussion about ongoing care with facility staff and patient/family; and additional application of dressings/padding. Further, based on the background discussion presented in the SoR for 11044 as compelling evidence, we do not believe that the RVW for 11047 requires work neutrality consideration.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. This add-on code is paired with 11044.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11044

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

Specialty surgeons How often? Commonly

Specialty nonsurgeons 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. estimate 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?
16,240 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimatation is based on percentage of current frequency for 11044 that may be larger than 20 sq cm.

Specialty surgeons Frequency 16039 Percentage 98.76 %

Specialty non-surgeons Frequency 201 Percentage 1.23 %

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 13133 - time and RVW more closely matched

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

Medicare Frequency Estimate

16,240	11047X	surg	ADDITIVE			16,039	99%	11047X	non-surg	ADDITIVE			201	1%
	53,021	55%	30%	x	1	8,748		53,021	19%	2%	x	1	201	
	53,021	55%	5%	x	2	2,916		53,021	19%	0%	x	2	-	
	53,021	55%	5%	x	3	4,374		53,021	19%	0%	x	3	-	

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
000, 010, or 090 Day Global Periods
Direct Inputs

CPT Long Descriptor:

GLOBAL	CPT	DESCRIPTOR
000	11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 square centimeters or less

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

A joint specialty panel representing general surgery and podiatry reviewed the practice expense details developed in 2001-2003 for 11042. The details were refined to reflect current PEAC standards and current practice.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: 11042 Non-facility: The global period will not impact the typical 5 minutes for diagnostic and referral forms necessary to perform this service, compared with a 90-day global procedure. Pre-surgery clearance will require at least one phone call (3 min). The patient will be contacted prior to surgery to verify prescribed changes in medications and pre-operative cleansing and diet (3 min).

11042 Facility: The global period will not impact the typical 5 minutes for diagnostic and referral forms necessary to perform this service, compared with a 90-day global procedure. Pre-surgery clearance with PCP and anesthesia services will require at least two phone calls (6 min). Shceduling facilty space and equipment/supplies with require at least one phone call (3 min). Pre-service education and review of peri-operative expectations, possible complications, and consent (5 min). The patient will be contacted prior to surgery to verify prescribed changes in medications and pre-operative cleansing and diet (3 min).

Intra-Service Clinical Labor Activities:
11042 Non-facility: Clinical staff will assemble/review prior imaging, lab, and/or pathology reports as necessary to be certain all pertinent materials are available for the physician (2 min is the standard for 99213). The procedure room is prepared for a messy procedure that includes irrigation. The patient is escorted to the procedure room and a gown is provided. Vitals are taken. The procedure and possible complications are reviewed. Assist physician with patient positioning and removal of dressings, padding, and any other wound cover. Assist the physician with application of topical and/or injectable anesthesthic as necessary. Assist the physician in performing the procedure (100% of physician time). Monitor after the procedure for bleeding and/or untoward reactions. Once the patient is stable, assist the physician with application of dressings. Complete lab form for specimen. Review at home dressing changes, activities and medication restrictions and needs, use of supports for walking (shoes/splints) or sitting/laying (cushions/pillows). Clean room and equipment, including instruments.

11042Facility: Clinical staff communicates with the facility staff, patient's family, insurance staff, and PCP/referring physician regarding discharge instructions and follow-up requirements. The standard 6-minutes for outpatient or 12 minutes for inpatient / next day discharge has been applied, as appropriate.

Post-Service Clinical Labor Activities:

11042 Non-facility: Three minutes is included for a follow-up phone call with the patient, caregiver, and/or PCP.
11042 Facility: No additional time added.

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

CPT Long Descriptor:

GLOBAL	CPT	DESCRIPTOR
ZZZ	11045	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 square centimeters, or part thereof

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

A panel of general surgeons discussed the practice expense details required for these add-on services and believe the only additional work would be the additional time to assist the physician in the non-facility setting. Further, we believe these large wounds will rarely be debrided in a non-facility setting.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:

Assist the physician with application of additional topical and/or injectable anesthetic; additional debridement and irrigation; and additional dressings, as necessary.

Post-Service Clinical Labor Activities:

N/A

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
000, 010, or 090 Day Global Periods
Direct Inputs

CPT Long Descriptor:

GLOBAL	CPT	DESCRIPTOR
0	11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 square centimeters or less
0	11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 square centimeters or less

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
A joint specialty panel representing general surgery and podiatry reviewed the practice expense details developed in 2002-2003 for 11043 and 11044. The details were refined to reflect current PEAC standards and current practice.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
Non-facility: The global period will not impact the typical 5 minutes for diagnostic and referral forms necessary to perform this service, compared with a 90-day global procedure. Pre-surgery clearance will require at least one phone call (3 min). The patient will be contacted prior to surgery to verify prescribed changes in medications and pre-operative cleansing and diet (3 min).
Facility: The global period will not impact the typical 5 minutes for diagnostic and referral forms necessary to perform this service, compared with a 90-day global procedure. Pre-surgery clearance with PCP and anesthesia services will require at least two phone calls (6 min). Scheduling facility space and equipment/supplies will require at least one phone call (3 min). Pre-service education and review of peri-operative expectations, possible complications, and consent (5 min). The patient will be contacted prior to surgery to verify prescribed changes in medications and pre-operative cleansing and diet (3 min).

Intra-Service Clinical Labor Activities:
Non-facility: Clinical staff will assemble/review prior imaging, lab, and/or pathology reports as necessary to be certain all pertinent materials are available for the physician. The procedure room is prepared for a messy procedure that includes irrigation. The patient is escorted to the procedure room and a gown is provided. Vitals are taken. The procedure and possible complications are reviewed. Assist physician with patient positioning and removal of dressings, padding, and any other wound cover. Assist the physician with application of topical and/or injectable anesthetic as necessary. Assist the physician in performing the procedure (100% of physician time). Monitor after the procedure for bleeding and/or untoward reactions. Once the patient is stable, assist the physician with application of dressings. Complete lab form for specimen. Review at home dressing changes, activities and medication restrictions and needs, use of supports for walking (shoes/splints) or sitting/laying (cushions/pillows). Clean room and equipment, including instruments.

Facility: Clinical staff communicates with the facility staff, patient's family, insurance staff, and PCP/referring physician regarding discharge instructions and follow-up requirements. The standard 6-minutes for outpatient or 12 minutes for inpatient / next day discharge has been applied, as appropriate.

Post-Service Clinical Labor Activities: N/A

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

CPT Long Descriptor:

GLOBAL	CPT	DESCRIPTOR
ZZZ	11046	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 square centimeters, or part thereof
ZZZ	11047	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 square centimeters, or part thereof

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

A panel of general surgeons discussed the practice expense details required for these add-on services and believe the only additional work would be the additional time to assist the physician in the non-facility setting. Further, we believe these large wounds will rarely be debrided in a non-facility setting.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:

Assist the physician with application of additional topical and/or injectable anesthetic; additional debridement and irrigation; and additional dressings, as necessary.

Post-Service Clinical Labor Activities:

N/A

	A	B	C	D	E	F	G
1	**AMA/Specialty Society RVS Update Committee Recommendation**						
2	**Meeting Date: February 2010**			**11042**		**11045**	
3				Debridement, subcutaneous tissue (includes epidermis and dermis, if		Debridement, subcutaneous tissue (includes epidermis and dermis, if	
4	**LOCATION**	**Code**	**Staff Type**	**OFF**	**FAC**	**OFF**	**FAC**
5	**GLOBAL PERIOD**			**0**	**0**	**ZZZ**	**ZZZ**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**68**	**22**	**15**	**0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**11**	**22**	**0**	**0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**54**	**0**	**15**	**0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**3**	**0**	**0**	**0**
10	**PRE-SERVICE**					**ADDITIONAL**	
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA	**5**	**5**	**0**	**0**
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	**3**	**6**	**0**	**0**
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA	**0**	**3**	**0**	**0**
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**0**	**5**	**0**	**0**
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	**3**	**3**	**0**	**0**
17	Other Clinical Activity (please specify)	**L037D**	RN/LPN/MTA				
18	**End:When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**					**ADDITIONAL**	
20	**Start: When patient enters site for procedure: Services Prior to Procedure**						
22	Greet Patient and Provide Gowning, Assure Appropriate Medical Records Are Available	**L037D**	RN/LPN/MTA	**3**			
23	Obtain vital signs	**L037D**	RN/LPN/MTA	**3**			
24	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**3**			
25	Prepare room, equipment, supplies	**L037D**	RN/LPN/MTA	**0**			
26	Setup scope (non facility setting only)	**L037D**	RN/LPN/MTA	**0**			
27	Prepare and position patient/ monitor patient/ set up IV	**L037D**	RN/LPN/MTA	**2**			
28	Sedate/apply anesthesia	**L037D**	RN/LPN/MTA	**2**			
29	**Intra-service**						
30	Assist physician in performing procedure	**L037D**	RN/LPN/MTA	**15**		**15**	
31	**Post-Service**						
32	Monitor pt following service/check tubes, monitors, drains	**L037D**	RN/LPN/MTA	**2**			
33	Clean room/equipment by physician staff	**L037D**	RN/LPN/MTA	**3**			
34	Clean Scope	**L037D**	RN/LPN/MTA	**0**			
35	Clean Surgical Instrument Package	**L037D**	RN/LPN/MTA	**10**			
36	Complete diagnostic forms, lab & X-ray requisitions	**L037D**	RN/LPN/MTA	**3**			
37	Review/read X-ray, lab, and pathology reports	**L037D**	RN/LPN/MTA	**0**			
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	**L037D**	RN/LPN/MTA	**8**			
39	Discharge day management	**L037D**	RN/LPN/MTA	**0**	**0**		
40	Other Clinical Activity: follow-up phone call	**L037D**	RN/LPN/MTA				
41	**End: Patient leaves office**						
42	**POST-SERVICE Period**						
43	**Start: Patient leaves office/facility**						
44	Conduct phone calls/call in prescriptions			**3**			
45	*Office visits*						
46	*List Number and Level of Office Visits*						
47	99211 16 minutes		16				
48	99212 27 minutes		27				
49	99213 36 minutes		36				
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	Other						
53	***Total Office Visit Time***	**L037D**	RN/LPN/MTA	**0**	**0**	**0**	**0**
54	***Other Total:***						
55	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
1	**AMA/Specialty Society RVS Update Committee Recommendation**						
2	**Meeting Date: February 2010**			**11042**		**11045**	
3				Debridement, subcutaneous tissue (includes epidermis and dermis, if		Debridement, subcutaneous tissue (includes epidermis and dermis, if	
4	**LOCATION**	**Code**	**Staff Type**	**OFF**	**FAC**	**OFF**	**FAC**
56	**MEDICAL SUPPLIES**	**Code**	**Unit**			**ADDITIONAL**	
57	pack, minimum multi-specialty visit	**SA048**	**pack**	**1**	**0**		
58	drape, sterile, for Mayo stand	**SB012**	**item**	**1**	**0**		
59	gown, staff, impervious	**SB027**	**item**	**2**	**0**		
60	underpad 2ft x 3ft (Chux)	**SB044**	**item**	**1**	**0**		
61	drape, sterile barrier 16in x 29in	**SB007**	**item**	**1**	**0**		
62	drape, sterile, fenestrated 16in x 29in	**SB011**	**item**	**1**	**0**		
63	gloves, sterile	**SB024**	**pair**	**1**	**0**		
64	basin, irrigation	**SJ009**	**item**	**1**	**0**	**0**	**0**
65	towel, non-sterile	**SB042**	**item**	**2**	**0**	**0**	**0**
66	sodium chloride 0.9% irrigation (500-1000ml uou)	**SH069**	**item**	**1**	**0**	**1**	**0**
67	syringe 50-60ml	**SC056**	**item**	**1**	**0**	**0**	**0**
68	blade, surgical (Bard-Parker)	**SF007**	**item**	**2**	**0**	**1**	**0**
69	culture swab system (Culturette)	**SL033**	**item**	**1**	**0**		
70	gauze, sterile 4in x 4in (10 pack uou)	**SG056**	**item**	**2**	**0**	**1**	**0**
71	dressing, 3in x 4in (Telfa, Release)	**SG035**	**item**	**2**	**0**	**2**	**0**
72	bandage, Kling, non-sterile 3in	**SG018**	**item**	**1**	**0**	**1**	**0**
73	gauze, self-adherent roll 0.5in to 2in (Fabco, Gauztex)	**SG052**	**inch**	**72**	**0**		
74	tape, surgical paper 1in (Micropore)	**SG079**	**inch**	**10**	**0**		
75	pack, cleaning, surgical instruments	**SA043**	**pack**	**1**	**0**		
76	**Equipment**	**Code**				**ADDITIONAL**	
77	table, power	**EF031**		**44**	**0**	**15**	**0**
78	light, surgical	**EF014**		**44**	**0**	**15**	**0**
79	instrument pack, basic ($500-$1499)	**EQ137**		**54**	**0**	**15**	**0**
80	mayo stand	**EF015**		**44**	**0**	**15**	**0**

	A	B	C	D	E	F	G
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**Apr 2010**		**Apr 2010**	
2	**Meeting Date: April 2010**			**11043**		**11046**	
3				Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 square centimeters or less		Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 square centimeters, or part thereof	
4	**LOCATION**	**Code**	**Staff Type**	**OFF**	**FAC**	**OFF**	**FAC**
5	**GLOBAL PERIOD**			**0**	**0**	**ZZZ**	**ZZZ**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**87**	**28**	**20**	**0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**11**	**22**	**0**	**0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**76**	**0**	**20**	**0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**0**	**6**	**0**	**0**
10	**PRE-SERVICE**					**ADDITIONAL**	
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	**3**	**6**		
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA		**3**		
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA		**5**		
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	**3**	**3**		
17	Other Clinical Activity (please specify)	**L037D**	RN/LPN/MTA				
18	**End:When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**					**ADDITIONAL**	
20	**Start: When patient enters site for procedure: Services Prior to Procedure**						
21	Greet Patient and Provide Gowning, Ensure Appropriate Medical Records Are Available	**L037D**	RN/LPN/MTA	**3**			
22	Obtain vital signs	**L037D**	RN/LPN/MTA	**3**			
23	Provide pre-service education/obtain consent						
24	Prepare room, equipment, supplies	**L037D**	RN/LPN/MTA	**2**			
25	Setup scope (non facility setting only)						
26	Prepare and position patient/ monitor patient/ set up IV	**L037D**	RN/LPN/MTA	**2**			
27	Sedate/apply anesthesia	**L037D**	RN/LPN/MTA	**2**			
28	**Intra-service**						
29	Assist physician in performing procedure	**L037D**	RN/LPN/MTA	**30**		**20**	
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	**15**			
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	**10**			
38	Discharge day management	**L037D**	RN/LPN/MTA				
40	**End: Patient leaves office**						
41	**POST-SERVICE Period**					**ADDITIONAL**	
42	**Start: Patient leaves office/facility**						
43	Conduct phone calls/call in prescriptions				**6**		
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***	**L037D**	**RN/LPN/MTA**	**0**	**0**	**0**	**0**
53	***Other Total:***						
54	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
1	**AMA/Specialty Society RVS Update Committee Recommendation**			Apr 2010		Apr 2010	
2	**Meeting Date: April 2010**			11043		11046	
3				Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 square centimeters or less		Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 square centimeters, or part thereof	
4	**LOCATION**	**Code**	**Staff Type**	**OFF**	**FAC**	**OFF**	**FAC**
55	**MEDICAL SUPPLIES**	**Code**	**Unit**			ADDITIONAL	
56	pack, minimum multi-specialty visit	SA048	pack	1			
57	drape, sterile, for Mayo stand	SB012	item	1			
58	gown, staff, impervious	SB027	item	2			
59	underpad 2ft x 3ft (Chux)	SB044	item	1			
60	drape, sterile barrier 16in x 29in	SB007	item	1			
61	drape, sterile, fenestrated 16in x 29in	SB011	item	1			
62	gloves, sterile	SB024	pair	2			
63	swab-pad, alcohol	SJ053	item	2			
64	syringe 10-12ml	SC051	item	1			
65	needle, 18-27g	SC029	item	2			
66	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	6		6	
67	basin, irrigation	SJ009	item	1			
68	towel, non-sterile	SB042	item	2			
69	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1		1	
70	syringe 50-60ml	SC056	item	1			
71	hydrogen peroxide	SJ028	ml	20		10	
72	blade, surgical (Bard-Parker)	SF007	item	3		1	
73	culture swab system (Culturette)	SL033	item	1			
74	silver nitrate applicator	SJ046	item	2			
75	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	2		1	
76	dressing, 3in x 4in (Telfa, Release)	SG035	item	2			
77	bandage, Kerlix, sterile 4.5in	SG016	item	2			
78	tape, surgical paper 1in (Micropore)	SG079	inch	12			
79	pack, cleaning, surgical instruments	SA043	pack	1			
80	**Equipment**	**Code**				ADDITIONAL	
81	table, power	EF031		61		20	
82	light, surgical	EF014		61		20	
83	instrument pack, medium ($1500 and up)	EQ138		76		20	
84	mayo stand	EF015		61		20	
85	light, exam	EQ168					

	A	B	C	D	E	F	G
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**Apr 2010**		**Apr 2010**	
2	**Meeting Date: April 2010**			**11044**		**11047**	
3				Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 square centimeters or less		Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 square centimeters, or part thereof	
4	**LOCATION**	**Code**	**Staff Type**	**OFF**	**FAC**	**OFF**	**FAC**
5	**GLOBAL PERIOD**			**0**	**0**	**ZZZ**	**ZZZ**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**102**	**28**	**30**	**0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**11**	**22**	**0**	**0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**91**	**0**	**30**	**0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**0**	**6**	**0**	**0**
10	**PRE-SERVICE**						**ADDITIONAL**
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA	**5**	**5**	**0**	**0**
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	**3**	**6**	**0**	**0**
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA	**0**	**3**	**0**	**0**
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**0**	**5**	**0**	**0**
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	**3**	**3**	**0**	**0**
17	Other Clinical Activity (please specify)	**L037D**	RN/LPN/MTA				
18	**End:When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						**ADDITIONAL**
20	**Start: When patient enters site for procedure: Services Prior to Procedure**						
21	Greet Patient and Provide Gowning, Ensure Appropriate Medical Records Are Available	**L037D**	RN/LPN/MTA	**3**			
22	Obtain vital signs	**L037D**	RN/LPN/MTA	**3**			
23	Provide pre-service education/obtain consent						
24	Prepare room, equipment, supplies	**L037D**	RN/LPN/MTA	**2**			
25	Setup scope (non facility setting only)						
26	Prepare and position patient/ monitor patient/ set up IV	**L037D**	RN/LPN/MTA	**2**			
27	Sedate/apply anesthesia	**L037D**	RN/LPN/MTA	**2**			
28	**Intra-service**						
29	Assist physician in performing procedure	**L037D**	RN/LPN/MTA	**45**		**30**	
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	**0**			
34	Clean Surgical Instrument Package	**L037D**	RN/LPN/MTA	**15**			
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	**0**			
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	**L037D**	RN/LPN/MTA	**10**			
38	Discharge day management	**L037D**	RN/LPN/MTA	**0**			
40	**End: Patient leaves office**						
41	**POST-SERVICE Period**						**ADDITIONAL**
42	**Start: Patient leaves office/facility**						
43	Conduct phone calls/call in prescriptions				**6**		
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***	**L037D**	**RN/LPN/MTA**	**0**	**0**	**0**	**0**
53	***Other Total:***						
54	**End: with last office visit before end of global period**						

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1	**AMA/Specialty Society RVS Update Committee Recommendation**			**Apr 2010**		**Apr 2010**	
2	**Meeting Date: April 2010**			**11044**		**11047**	
3				Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 square centimeters or less		Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 square centimeters, or part thereof	
4	**LOCATION**	**Code**	**Staff Type**	**OFF**	**FAC**	**OFF**	**FAC**
55	**MEDICAL SUPPLIES**	**Code**	**Unit**			**ADDITIONAL**	
56	pack, minimum multi-specialty visit	**SA048**	**pack**	**1**			
57	drape, sterile, for Mayo stand	**SB012**	**item**	**1**			
58	gown, staff, impervious	**SB027**	**item**	**2**			
59	underpad 2ft x 3ft (Chux)	**SB044**	**item**	**1**			
60	drape, sterile barrier 16in x 29in	**SB007**	**item**	**1**			
61	drape, sterile, fenestrated 16in x 29in	**SB011**	**item**	**1**			
62	gloves, sterile	**SB024**	**pair**	**2**			
63	swab-pad, alcohol	**SJ053**	**item**	**2**			
64	syringe 10-12ml	**SC051**	**item**	**1**			
65	needle, 18-27g	**SC029**	**item**	**2**			
66	lidocaine 1%-2% inj (Xylocaine)	**SH047**	**ml**	**6**		**6**	
67	basin, irrigation	**SJ009**	**item**	**1**			
68	towel, non-sterile	**SB042**	**item**	**2**			
69	sodium chloride 0.9% irrigation (500-1000ml uou)	**SH069**	**item**	**1**		**1**	
70	syringe 50-60ml	**SC056**	**item**	**1**			
71	hydrogen peroxide	**SJ028**	**ml**	**20**		**10**	
72	blade, surgical (Bard-Parker)	**SF007**	**item**	**3**		**1**	
73	culture swab system (Culturette)	**SL033**	**item**	**1**			
74	silver nitrate applicator	**SJ046**	**item**	**2**			
75	gauze, sterile 4in x 4in (10 pack uou)	**SG056**	**item**	**1**		**1**	
76	dressing, 3in x 4in (Telfa, Release)	**SG035**	**item**	**2**		**1**	
77	bandage, Kerlix, sterile 4 5in	**SG016**	**item**	**2**			
78	tape, surgical paper 1in (Micropore)	**SG079**	**inch**	**12**			
79	pack, cleaning, surgical instruments	**SA043**	**pack**	**1**			
80	**Equipment**	**Code**				**ADDITIONAL**	
81	table, power	**EF031**		**76**		**30**	
82	light, surgical	**EF014**		**76**		**30**	
83	instrument pack, medium ($1500 and up)	**EQ138**		**91**		**30**	
84	mayo stand	**EF015**		**76**		**30**	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five-Year Review – Codes Reported Together Screen

February 2010

Arthrodesis Including Discectomy

In February 2008, the RUC reviewed 22554 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical, below C2* as part of its Codes Reported Together Screen. The codes were then referred to the CPT Editorial Panel to create a new coding structure for the family of services. In October 2009, the CPT Editorial Panel approved two new codes, 22551 and 22552, to describe fusion and discectomy of the anterior cervical spine.

22551

The RUC reviewed the survey results for code 22551 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical, below C2* and agreed with the specialty society that the pre-service time package 4- FAC Difficult Patient/Difficult Procedure underestimates the amount of time required to perform this service. Patients have spinal cord compression in addition to spinal nerve root compression and thereby require significant education due to the complexity, scope and risks (eg fusion non-union and/or adjacent segment disease) associated with this service. Also, additional pre-service time was added to the positioning time for anterior neck surgery. Thus the RUC agreed to the following pre-service time components: pre-service evaluation = 60 minutes, pre-service positioning = 18 minutes and pre-service scrub, dress, wait = 20 minutes.

The RUC compared the surveyed code to the key reference code 22856 *Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical* (Work RVU = 24.05) and noted that the surveyed code has an additional 18 minutes total service time than the reference code, 395 minutes and 377 minutes respectively. The survey respondents also indicated that this service was slightly more intense service to perform in comparison to the reference code. Therefore, to account for the difference in work RVUs for these codes, the RUC agreed that 24.50 Work RVUs, a value slightly below the 25th percentile accurately reflects the work required to perform this service. This service was previously reported with CPT code 22554 (Work RVU = 8.85 after multiple service reduction) and code 63075 (Work RVU = 19.60), resulting in a current work RVU of 28.45. Therefore, the RUC recommendation results in a reduction in total work RVUs. **The RUC recommends 24.50 Work RVUs for 22551.**

22552
The RUC reviewed the survey results for code 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace* and agreed with the specialty society that the survey respondents' median pre-service (5 minutes) and intra-service (45 minutes) times were reflective of the service. The RUC concurred that 5 minutes of pre-service evaluation time was necessary to account for the additional physician work related to assessing and discussing the risks and possible complications which are greater for surgery of multiple levels of the cervical spine.

The RUC compared the surveyed code to the key reference code 22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment* (Work RVU=6.43). The RUC noted that the intra-service time for the surveyed code is higher than the reference code, 45 minutes and 40 minutes, respectively. Furthermore, the RUC noted that the surveyed code required slightly more mental effort and judgment to perform than the reference code. Given these comparisons, the RUC agreed that the survey's 25th percentile, 6.50 RVUs, is an appropriate value for this service. This service was previously reported with CPT code 22585 *Arthrodesis, anterior interbody technique including minimal discectomy to prepare interspace(other than for decompression); cervical below C2, each additional interspace* (Work RVU = 5.52) and code 63076 *Discectomy, anterior, with decompression of spinal cord and/or nerve roots, including osteophytectomy; cervical, each additional level* (Work RVU = 4.04) for a total work RVU of 9.56. Therefore, the RUC recommendation results in a significant decrease in total work RVUs. **The RUC recommends 6.50 Work RVUs for 22552.**

678

Practice Expense
The RUC reviewed these services and direct inputs carefully and agreed that these services have similar facility practice expenses as other complex spine procedures. The RUC agreed that 75 minutes of pre-service time is appropriate rather than the standard 90 day global pre-service time of 60 minutes. These services are performed in the facility setting only.

Work Neutrality
The RUC's recommendation for these 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
•22551	H1	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical, below C2	090	24.50
•+22552	H2	cervical below C2, each additional interspace (List separately in addition to code for separate procedure)	ZZZ	6.50
22554		Arthrodesis, anterior interbody technique including minimal discectomy to prepare interspace (other than for decompression); cervical below C2 (Do not report 22554 in conjunction with 63075, even if performed by separate providers. To report anterior cervical discectomy and interbody fusion at the same level during the same session, use 22551)	090	17.69 (No Change)
▲+22585		cervical below C2, each additional interspace (List separately in addition to code for separate procedure) (Do not report 22585 in conjunction with 63075, even if performed by separate providers; for reporting anterior cervical discectomy and interbody fusion at the same level during the same session, use 22552)	ZZZ	5.52 (No Change)
Nervous System **Spine and Spinal Cord** **Anterior or Anterolateral Approach for Extradural Exploration/Decompression**				
63075		Discectomy, anterior, with decompression of spinal cord and/or nerve roots, including osteophytectomy; cervical, single interspace (Do not report 63075 in conjunction with 22554, even if performed by separate providers. To report anterior cervical discectomy and interbody fusion at the same level during the same session, use 22551)	090	19.60 (No Change)

679

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
+63076		cervical, each additional level (List separately in addition to code for separate procedure) (Do not report 63076 in conjunction with 22554, even if performed by separate providers. To report anterior cervical discectomy and interbody fusion at the same level during the same session, use 22552)	ZZZ	4.04 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22551 Tracking Number H1 Specialty Society Recommended RVU: **25.00**
Global Period: 090 RUC Recommended RVU: **24.5**

CPT Descriptor: Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical, below C2

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47-year-old woman has 3 months of neck pain radiating into the right hand with numbness, tingling, weakness, and gait difficulty. Six weeks of non-operative treatment are unsuccessful and imaging studies identify C6-C7 spondylosis and right disc protrusion. Examination shows mild triceps weakness with an absent right triceps reflex and decreased pinprick sensation in the right long finger. The patient has an extensor plantar response and mild hyperpathia in the lower limbs. An anterior C6-C7 decompression with discectomy, osteophytectomy, and C7 foraminotomy is performed followed by preparation of the disc space and end plates for arthrodesis.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 5% , Kept overnight (less than 24 hours) 8% , Admitted (more than 24 hours) 86%

Percent of survey respondents 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%

Moderate Sedation

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

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

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

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

Description of Intra-Service Work:
A transverse incision is made anteriorly over the level of the proposed arthrodesis. The platysma muscle is cut in line with the skin incision. The interval between the sternocleidomastoid and carotid sheath laterally and the trachea and esophagus medially is developed and the prevertebral fascia cleared from the front of the spine. The disc between the vertebrae to be fused is identified and the level confirmed by imaging. The longus colli muscles are mobilized along their medial edge Lateral and longitudinal self retaining traction devices are inserted. The anterior longitudinal ligament and anterior annulus are removed by sharp dissection. The disc space is distracted and an operating microscope is utilized to visualize the posterior portion of the disc. Additional disc material and osteophytes are removed to decompress the spinal canal and nerve root(s). The remainder of the disc and cartilage are removed by curettage in preparation for arthrodesis. The bone endplates are shaped with a high speed drill to create two parallel surfaces. The height, depth and width are measured. With the disc space under distraction, the intervertebral implant (coded separately) is inserted into the disc space to accomplish fusion. Final position of the intervertebral implant is confirmed by imaging. The distraction is released and the graft checked for security. Any protruding parts of the graft are trimmed to avoid esophageal compression. A drain is placed in the wound, as necessary. The platysma muscle, subcutaneous tissue, and skin are closed in layers.

Description of Post-Service Work:
Hospital: Sterile dressings and a collar or brace are applied. When anesthesia has been reversed, transfer patient to the recovery room. Write an OP note in the patient's record. Examine patient, check wound(s) and patient progress, monitor for abnormal neurological findings. Sign OR forms, including pre- and postoperative diagnosis, operations performed. Discuss procedure outcome with family. Dictate postop report. Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company. Order and review films to check alignment of cervical spine. Write orders daily, as necessary, for medications, diet, and patient activity. Examine patient daily, check wounds and patient progress. Review nursing/other provider chart notes. Chart patient progress notes. Discuss patient progress with referring physician (verbal and written). Answer patient/family questions; nursing/other provider questions (verbal and written); and insurance staff questions. At discharge, review post-discharge wound care, use and proper fit of collar, and activity limitations, including planned physical therapy. Answer patient/family questions, nursing/other provider questions. Write orders for post-discharge films, medications, and therapy. Chart patient discharge notes
Office: Examine patient - perform periodic neurological exams. Write orders for medications. Order and review follow-up films. Monitor wounds and remove sutures/staples, when appropriate. Review use and proper fit of collar with patient Review physical therapy progress and revise orders as needed. Dictate patient progress notes for medical chart. Answer patient/family questions and insurance staff questions. Discuss patient progress with referring physician (verbal and written).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010					
Presenter(s):	John Wilson, MD; Edward Vates, MD; Alexander Mason, MD; Willam Creevy, MD; Charles Mick, MD; William Sullivan, MD					
Specialty(s):	neurosurgery, orthopaedic surgery, spine surgery					
CPT Code:	22551					
Sample Size:	1826	**Resp N:**	202	**Response:** 11.0 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	25.00	**40.00**	64.00	300.00
Survey RVW:	18.00	25.00	**27.00**	32.00	45.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**20.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	50.00	90.00	**120.00**	120.00	240.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	22551	**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:		**60.00**	**40.00**	**20.00**
Pre-Service Positioning Time:		**18.00**	**3.00**	**15.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**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):	**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? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22856	090	24.05	**RUC Time**

CPT Descriptor Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
		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: 109 **% of respondents:** 53.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 22551**	**Key Reference CPT Code: 22856**	**Source of Time RUC Time**
Median Pre-Service Time	98.00	80.00	
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	40.0	40.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	69.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**395.00**	**377.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.80	3.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.81	3.78
Urgency of medical decision making	3.43	3.31
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.35	4.34
Physical effort required	3.71	3.69
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.28	4.21
Outcome depends on the skill and judgment of physician	4.39	4.31
stimated risk of malpractice suit with poor outcome	4.48	4.43

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.64	3.67
Intra-Service intensity/complexity	4.11	4.06
Post-Service intensity/complexity	3.20	3.15

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 ecommendations for the appropriate formula and format.*

The CPT/RUC Joint Workgroup on Bundled Services identified "Type B" codes 22554 and 63075 as typically billed together by the same physician at the same operative session and required that a bundled code for the work be developed.

New code 22551 was created to bundle codes 22554 and 63075 to describe fusion and discectomy of the anterior cervical spine. Both codes 22554 and 63075 were reviewed by the RUC during the third 5YR.

A new RUC survey was conducted jointly by the AANS/CNS, AAOS, and NASS, with 202 survey responses. A majority of the respondents appropriately indicated that the patient was typically admitted (86%).

The multi-specialty expert panel reviewing 22551 recommend pre-time package 4 difficult patient/difficult procedure with an additional 15 of positioning time for anterior neck surgery. The expert panel also recommends the survey 25th percentile RVW of 25.00, which is less than the previously billed combined services of 22554 and 63075 (28.45 RVW when adjusted for the -51 modifier).

The expert panel felt the 25th percentile RVW more appropriately took into account the difference between median survey intra time of 120 minutes and the intra time of 90 minutes for the base codes as well as the difference in post op 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: 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.
   There is no typical coding scenario that describes the circumstances in which this code may be reported with other codes. The codes that typically would be coded with 225X1 are ZZZ add-on codes.The following is a list of ZZZ codes that may or may not be used with 225X1:

225X2 Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace ,
20931Allograft for spine surgery only; structural,
20938 Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision)
22851 Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace
22845 Anterior instrumentation; 2 to 3 vertebral segments
22846 Anterior instrumentation; 4 to 7 vertebral segments

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 22554 and 63075

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

Specialty neurosurgery How often? Commonly

Specialty orthopaedic surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 80000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate would 2 to 3 times the Medicare frequency.

Specialty neurosurgery Frequency 56000 Percentage 70.00 %

Specialty orthopaedic surgery Frequency 24000 Percentage 30.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 23,700 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This value is approximately 95% of the Medicare 2008 frequency for 63075.

Specialty neurosurgery Frequency 16590 Percentage 70.00 %

Specialty orthopaedic surgery Frequency 7110 Percentage 30.00 %

Specialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) 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:22552 Tracking Number H2 Specialty Society Recommended RVU: **6.50**
Global Period: ZZZ RUC Recommended RVU: **6.50**

CPT Descriptor: Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old woman has a 3 month history of neck pain with radiation into her arms and hands with bilateral hand numbness, tingling, weakness, and gait difficulty. Three months of non-operative treatment are unsuccessful and imaging studies identify C5-C6, C6-C7 spondylosis and central disc protrusion with spinal cord compression. Examination shows biceps and triceps weakness with an absent triceps reflex and decreased pinprick sensation in the thumb, index, and long fingers bilaterally. The patient has a positive Hoffman's reflex and an extensor plantar response and mild hyperpathia in the lower limbs. With the C5-C6 discectomy/fusion completed, an anterior C6-C7 decompression with discectomy, osteophytectomy, and C6-C7 foraminotomy is performed followed by preparation of the disc space and end plates for arthrodesis. [NOTE: This is an add-on code. When completing this survey consider only the additional physician work.]

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

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

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

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

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

Moderate Sedation

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

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

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

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

Description of Intra-Service Work:
During the same operative session for a single level anterior cervical discectomy fusion, a second cervical intervertebral disc level is exposed and the retractors are adjusted. The anterior longitudinal ligament and annulus are incised and removed. The disc material is removed along the cartilaginous endplate. The sterilely draped operating microscope is returned to the field and the posterior longitudinal ligament is resected. The osteophyte is resected with a micro angled

curette decompressing the spinal cord and neural foramen. The decompression is confirmed with a nerve hook. The end plates are prepared with a curette to remove all disc material and cartilage. A high-speed drill is used to decorticate the boney end plate. An intervertebral implant is then sized to the appropriate dimensions and tapped into the disc space to accomplish fusion. Placement is confirmed with imaging.

Description of Post-Service Work:
N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	John Wilson, MD; Edward Vates, MD; Alexander Mason, MD; Willam Creevy, MD; Charles Mick, MD; William Sullivan, MD				
Specialty(s):	neurosurgery, orthopaedic surgery, spine surgery				
CPT Code:	22552				
Sample Size:	1826	**Resp N:** 109	**Response:** 5.9 %		
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**35.00**	50.00	100.00
Survey RVW:	4.00	6.50	**10.00**	12.00	15.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	20.00	30.00	**45.00**	60.00	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: ZZZ Global Code

CPT Code:	22552	**Recommended Physician Work RVU: 6.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
22614	ZZZ	6.43	**RUC Time**

CPT Descriptor Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (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
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
		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:** 21.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 22552**	**Key Reference CPT Code: 22614**	**Source of Time**
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	45.00	40.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**50.00**	**40.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.96	3.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.04	3.65
Urgency of medical decision making	3.48	0.04
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.13	3.52
Physical effort required	3.91	3.35
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.04	3.35
Outcome depends on the skill and judgment of physician	4.22	3.61
Estimated risk of malpractice suit with poor outcome	4.30	3.65

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.09	3.64
Intra-Service intensity/complexity	4.04	3.35
Post-Service intensity/complexity	3.57	3.43

Additional Rationale and Comments

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

The CPT/RUC Joint Workgroup on Bundled Services identified "Type B" codes 22554 and 63075 as typically billed together by the same physician as the same operative session and required that a bundled code for the work be developed.

New code 22552 was created to report each additional level of the bundled work of fusion and discectomy of the anterior cervical spine. Add-on code 22585 was reviewed by the RUC in 1995. Code 63076 was never reviewed by the RUC.

A RUC survey was conducted jointly by the AANS/CNS, AAOS, and NASS, with 109 survey responses. The multi-specialty expert panel reviewing 22552 recommends 5 minutes of additional pre-service time for this bundled add-on code to account for the additional physician work related to assessing and discussing the risks and possible complications which are greater for surgery of multiple levels of the cervical spine. Also, additional review and consideration of type of graft and need for plate is required.

The expert panel recommends the survey 25th percentile RVW of 6.50, which is significantly less than the previously billed discreet add-on services 22585 and 63076.

SERVICES REPORTED WITH MULTIPLE 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.
   There is no other code that could specifically be coded with 225X2 other than 225X1, which is the base code for this add-on code. There is a wide range of additional add-on codes that may or may not be coded with 225X1 or the combination of 25X1 and 225X2. These are listed in the SOR for the base code 225X1.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 22585 and 63076

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

Specialty neurosurgery How often? Commonly

Specialty orthopaedic surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 45000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate would 2 to 3 times the Medicare frequency.

Specialty neurosurgery Frequency 31500 Percentage 70.00 %

Specialty orthopaedic surgery Frequency 13500 Percentage 30.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 17,700 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This value is approximately 95% of the Medicare 2008 frequency for 63076.

Specialty neurosurgery Frequency 12390 Percentage 70.00 %

Specialty orthopaedic surgery Frequency 5310 Percentage 30.00 %

Specialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) 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, 010, or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

22551 Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical, below C2

Global Period 090

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

A joint specialty panel representing neurosurgery, orthopaedic surgery, and spine surgery discussed the practice expense requirements for 22551 and determined that the standard 90-day global inputs would apply.

This is a facility only code.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

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

Intra-Service Clinical Labor Activities:

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

Post-Service Clinical Labor Activities:

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

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

CPT Long Descriptor:

22552 Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace

Global Period ZZZ

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

A joint specialty panel representing neurosurgery, orthopaedic surgery, and spine surgery discussed the practice expense requirements for 22551 and determined that the standard 90-day global inputs would apply.

This is a facility only code.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			H1		H2	
2				22551		22552	
3	**Meeting Date: February 2010**			Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical, below C2		Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace	
4	**LOCATION**	**Code**	**Staff Type**	**OFF**	**FAC**	**OFF**	**FAC**
5	**GLOBAL PERIOD**			**90**	**90**	**ZZZ**	**ZZZ**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**195**	**n/a**	**0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**75**	**n/a**	**0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**12**	**n/a**	**0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**108**	**n/a**	**0**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA	**0**	**5**	**0**	**0**
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	**0**	**20**	**0**	**0**
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA	**0**	**8**	**0**	**0**
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**0**	**20**	**0**	**0**
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	**0**	**7**	**0**	**0**
17	Other Clinical Activity: coordination of care	**L037D**	RN/LPN/MTA		**15**		
18	**End:When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters site for procedure: Services Prior to Procedure**						
39	Discharge day management	**L037D**	RN/LPN/MTA	**0**	**12**	**0**	**0**
41	**End: Patient leaves office**						
42	**POST-SERVICE Period**						
43	**Start: Patient leaves office/facility**						
44	Conduct phone calls/call in prescriptions						
45	*Office visits:*						
46	*List Number and Level of Office Visits*						
47	99211 16 minutes		16				
48	99212 27 minutes		27				
49	99213 36 minutes		36	**0**	**3**	**0**	**0**
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	Other						
53	***Total Office Visit Time***	**L037D**	**RN/LPN/MTA**	**0**	**108**	**0**	**0**
54	***Other Total:***						
55	**End: with last office visit before end of global period**						
56	**MEDICAL SUPPLIES**	**Code**	**Unit**				
57	pack, minimum multi-specialty visit	**SA048**	**pack**	**0**	**3**	**0**	**0**
58	pack, post-op incision care (suture & staple)	**SA053**	**pack**	**0**	**1**	**0**	**0**
59	**Equipment**	**Code**					
60	table, power	**EF031**		**0**	**108**	**0**	**0**
61	light, surgical	**EF014**		**0**	**108**	**0**	**0**

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five Year Review - High Volume Growth and CMS Fastest Growing Screens

April 2010

Endovascular Revascularization

The RUC identified the endovascular revascularization procedures as potentially misvalued based on the recommendation of the Five-Year Review Identification Workgroup. These codes were referred to the Workgroup for review via the CMS Fastest Growing Screen and High Volume Growth Screen. The specialty societies explained to the RUC that these services need to be clarified through the CPT Editorial Panel process to clearly define the four treatment modalities (angioplasty, stenting, arthrectomy, and stenting plus arthrectomy) that are applied in three different arterial beds (iliac, femoropopiteal and tibial). Further, all of the percutaneous vascular intervention procedures are currently reported with the component coding approach, meaning that at least three codes are used to report each treatment at any single level in the arterial tree. The three codes currently reported include: 1.) a selective catheterization code, plus 2.) a radiological supervision and interpretation code and 3.) a treatment code. The new structure bundles these three services into one code.

701

37205 Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel, **37206** Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel, **37207** Transcatheter placement of an intravascular stent(s) (non-coronary vessel other than iliac and lower extremity arteries), open; initial vessel, **37208** Transcatheter placement of an intravascular stent(s) (non-coronary vessel other than iliac and lower extremity arteries), open; each additional vessel, **75960** Transcatheter introduction of intravascular stent(s) (except coronary, carotid, ~~and~~, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel, **75962** Transluminal balloon angioplasty, peripheral artery other than iliac or lower extremity, radiological supervision and interpretation and **75964** Transluminal balloon angioplasty, each additional peripheral artery other than iliac and lower extremity, radiological supervision and interpretation

The specialty societies have requested that the full RUC survey and RUC review of these services be postponed until after the family of new lower extremity interventional codes has been implemented and the societies have a better estimate of the volume shifts and definition of the typical patient for these remaining procedures. **The RUC recommends the postponement of the review of 37205,**

37206, 37207, 37208, 75960, 75962 and 75964 until after the new lower extremity interventional codes has been implemented. The RUC recommends that the current values be maintained.

37220 Revascularization, iliac artery, unilateral, initial vessel; with transluminal angioplasty
The RUC reviewed the survey data from 129 cardiologists, vascular surgeons and radiologists for the new bundled code, 37220. This code describes a service that was previously reported with the existing iliac angioplasty code (35473 = 6.03 RVUs) plus the existing radiological S&I code for balloon angioplasty (75962 = 0.54 RVUs) plus a catheterization code, either 36200, 36245 or 36246 for this procedure depending on the access site chosen and the exact target vessel. To best estimate the work of the catheterization code selected, the specialty society took an average of these three codes (4.32 RVUs) and reduce that value by 50% for the multiple procedure reduction (thus, 4.32 x 0.5=2.16) resulting in an estimate of 8.73 RVUs for the typical iliac angioplasty case.

The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriately positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 36478 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated* (Work RVU=6.72). The RUC noted that the surveyed code has more intra-service work as compared to the reference code, 60 minutes and 55 minutes respectively. Further, the RUC noted that the surveyed code requires significantly more mental effort and judgment, technical skill, and results in more psychological stress as compared to the reference code. Based on these comparisons to the reference code, the specialty societies recommend and the RUC agreed that the survey median, 8.15 RVUs, accurately reflects the work required to perform this service. **The RUC recommends 8.15 Work RVUs for 37220.**

37221 Revascularization, iliac artery, unilateral, initial vessel; with transluminal stent placement(s)
The RUC reviewed the survey data from 126 cardiologists, vascular surgeons and radiologists for new bundled code, 37221. This code describes a service that was previously reported with the existing stent code (37205 = 8.27 RVUs) plus the existing radiological S&I code for stent (75960 = 0.82 RVUs) plus one catheterization code, either 36200, 36245 or 36246 depending on the access site chosen and the exact target vessel. To best estimate the work of the catheterization code selected, the specialty society took an average of these three codes (4.32 RVUs) and reduce it by 50% for multiple procedure reduction (thus, 2.16 Work RVUs). In addition, many current providers additionally report a balloon angioplasty and angioplasty S&I code during an iliac stent procedure

(balloon is 35473 = 6.03 RVUs cut by 50% for multiple procedure = 3.02, and angioplasty S&I is 0.54). This component coding resulted in an estimate of 14.81 work RVUs for placement of an iliac stent. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriately positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 92980 *Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel* (Work RVU=14.82). The RUC noted that the surveyed code has less intra-service work as compared to the reference code, 90 minutes and 120 minutes respectively. Further, the RUC noted that the reference code requires more medical decision making, physical effort, and results in more psychological stress as compared to the surveyed code. Based on these comparisons to the reference code, the specialty societies recommend and the RUC agreed that the survey median, 10.00 RVUs, accurately reflects the work required to perform this service. **The RUC recommends 10.00 Work RVUs for 37221.**

703

37222 Revascularization, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure

The RUC reviewed the survey data from 79 cardiologists, vascular surgeons and radiologists for the new bundled code, 37222. This code describes a service that was previously reported with the iliac angioplasty code (35473 = 6.03 RVUs) plus the existing radiological S&I code for balloon angioplasty (75962 = 0.54 RVUs) resulting in an estimate of 6.57 RVUs for the typical iliac angioplasty patient. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that the additional minute of pre-service time represents the time required for the physician to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, the order to proceed, the approach to use and the impact the second site will have on the potential use of an embolic protection device. The specialty society explained that the additional minute of post-service time represents the additional time to review extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation. Additionally, more attention is required for the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion. The RUC reviewed the physician work of CPT Code 60512 *Parathyroid autotransplantation (List separately in addition to code for primary procedure)* (ZZZ global, 45 minutes intra-service time, Work RVU = 4.44) and agreed this service was more intense and has more overall physician work than the new code. The RUC also reviewed CPT Code 49329 *Laparoscopy, surgical; with omentopexy (omental tacking procedure) (List separately in addition to code for primary procedure)* (ZZZ Global, 45 minute intra-service time, Work RVU = 3.50) and agreed this service was less intense and contains less physician work per minute than the new code.

The specialty societies indicated that CPT Code 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (ZZZ Global, 40 minutes intra-service time, Work RVU = 3.73) is very similar in overall physician work and intensity to new code 37222. The RUC concurred that the physician work value for the new code should be below the specialty's 25th percentile survey work value of 4.12 and relative to other ZZZ global codes with similar intra-service time. The RUC agreed that the value of 37222 should be directly crosswalked from 14302. **The RUC recommends 3.73 Work RVUs for 37222, a value just below the 25th percentile.**

37223 Revascularization, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s)
The RUC reviewed the survey data from 79 cardiologists, vascular surgeons and radiologists for the new bundled code, 37223. This code describes a service that was previously reported with add-on stent code (37206 = 4.12 RVUs) and its associated S&I code (75960 = 0.82) resulting in an estimate of 4.94 Work RVUs. In some instances, providers will report only these two codes, while others will additionally report a iliac angioplasty code (35473 = 3.02 RVUs after 50% reduction) plus the existing radiological S&I code for balloon angioplasty (75962 = 0.54 RVUs) for a total of 8.50 work RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that the additional minute of pre-service time represents the time required for the physician to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, the order to proceed, the approach to use and the impact the second site will have on the potential use of an embolic protection device. The specialty society explained that the additional minute of post-service time represents the additional time to review extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation. Additionally, more attention is required for the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion. The RUC reviewed the surveyed code in comparison to the reference code 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel* (Work RVU=4.12). The RUC noted that the surveyed code has more intra-service time as compared to the reference code, 45 minutes and 30 minutes, respectively. Further, the RUC noted that the surveyed code was a slightly more intense procedure to perform in comparison to the reference code. Based on these comparisons, the specialty societies agree that 4.25 work RVUs, the survey's 25th percentile, accurately reflects the work required to perform the service. **The RUC recommends 4.25 Work RVUs for 37223.**

37224 Revascularization, femoral/popliteal artery(s), unilateral; with transluminal angioplasty
The RUC reviewed the survey data from 89 cardiologists, vascular surgeons and radiologists for new bundled code. 37224. This code describes a service that was previously reported with the existing fem-pop angioplasty code (35474 = 7.35 RVUs) plus the existing radiological S&I code for balloon angioplasty (75962 = 0.54 RVUs) plus one catheterization code that would be used for this procedure, typically 36247 (6.29 RVUs), resulting in 11.04 RVUs. The RUC agreed with the specialty societies' recommended

physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for the selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriately positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 61640 *Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel* (Work RVU=12.32). The RUC noted that although the survey respondents indicated that the surveyed code and 92980 are similarly intense services, the reference code has significantly more total physician time as compared to the surveyed code, 227 minutes and 158 minutes, respectively. The specialty societies addressed the high intensity of this service by explaining that 37224 represents the bundling of services which includes the removal of duplicative pre- and post-service time, lower intense activities, and leaves only the higher intense components, the intra-service time, bundled 37224. The RUC agrees that the high intensity of this service is appropriate in comparison to the reference code and maintains rank order with the intensities associated with the endovascular aneurysm codes. Based on these comparisons to the reference code, the specialty societies recommend and the RUC agrees that the survey median, 9.00 RVUs, accurately reflects the work required to perform this service. **The RUC recommends 9.00 Work RVUs for 37224.**

705

37225 Revascularization, femoral/popliteal artery(s), unilateral; with atherectomy

The RUC reviewed the survey data from 82 cardiologists, vascular surgeons and radiologists for new bundled code, 37225. This code describes a service that was previously reported with the existing atherectomy code (35493 = 8.09 RVU) plus the existing radiological S&I code for atherectomy (75992 = 0.54 RVU) plus one catheterization code, typically 36247 (3.15 RVUs after 50% payment reduction), resulting in 11.78 Work RVUs. In addition, many providers additionally report a balloon angioplasty and balloon angioplasty S&I during an atherectomy procedure (35474 = 7.35 RVUs cut by 50% for multiple procedure = 3.68, plus 0.54 for the angioplasty S&I), resulting in 16.00 work RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for the selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriate positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 37184 *Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel* (Work RVU=8.66). The RUC noted that the surveyed code has more intra-service work as compared to the reference code, 118 minutes and 90 minutes, respectively. Further, the RUC

noted that the surveyed code requires more mental effort and judgment, physical effort, and results in more psychological stress as compared to the surveyed code. Based on these comparisons to the reference code, the specialty societies recommend and the RUC agrees that the survey median, 12.00 RVUs, accurately reflects the work required to perform this service. **The RUC recommends 12.00 Work RVUs for 37225.**

37226 Revascularization, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s)
The RUC reviewed the survey data from 89 cardiologists, vascular surgeons, and radiologists for new bundled code, 37226. This code describes a service that was previously reported with the existing stent code (37205 = 8.27 RVU) plus the existing radiological S&I code for peripheral stent (75960 = 0.82 RVU) plus one catheterization code (36247 = 3.15 RVUs after the 50% multiple procedure reduction), resulting in 12.24 Work RVUs. In addition, many providers also report a balloon angioplasty (35474, 7.35 RVU) and balloon angioplasty S&I (75962, 0.54 RVU) during a fem/pop stent procedure, resulting in 16.46 Work RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for the selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriate positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 92980 *Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel* (Work RVU=14.82). The RUC noted that although the survey respondents indicated that the surveyed code was overall a more intense service to perform in comparison to 92980, the reference code has significantly more intra-service time as compared to the surveyed code, 120 minutes and 90 minutes, respectively. The specialty societies addressed the high intensity of this service by explaining that 37226 represents the bundling of services which includes the removal of duplicative pre- and post-service time, lower intense activities, and leaves only the higher intense components, the intra-service time, bundled 37226. The RUC agrees that the high intensity of this service is appropriate in comparison to the reference code and maintains rank order with the intensities associated with the endovascular aneurysm codes. Based on these comparisons to the reference code, the specialty societies recommend and the RUC agrees that the survey median, 10.49 RVUs, accurately reflects the work required to perform this service. **The RUC recommends 10.49 Work RVUs for 37226.**

37227 Revascularization, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy
The RUC reviewed the survey data from 83 cardiologists, vascular surgeons an radiologists for new bundled code, 37227. This code describes a service that was previously reported with the existing stent code (37205 = 8.27 RVU) plus the existing radiological S&I code for peripheral stent (75960 = 0.82 RVU) plus one catheterization code, typically 36247 (3.15 Work RVUs after the 50% multiple

706

procedure reduction) plus one atherectomy code (35493 = 4.05 Work RVUs after the 50% multiple procedure reduction) plus one atherectomy S&I (75992 = 0.54 RVU), resulting in 16.83 work RVUs. In addition, many providers additionally report a balloon angioplasty and balloon angioplasty S&I during this procedure (35474 = 7.35 RVUs cut by 50% for multiple procedure = 3.66 plus 0.54 for the angioplasty S&I), resulting in 21.03 Work RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for the selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriate positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 37182 *Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)* (Work RVU=16.97). The RUC noted that the surveyed code has less intra-service work as compared to the reference code, 125 minutes and 150 minutes, respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment, physical effort, resulting in more psychological stress as compared to the surveyed code. Based on these comparisons to the reference code, the specialty societies recommend and the RUC agrees that the survey median, 14.50 RVUs, accurately reflects the work required to perform this service. **The RUC recommends 14.50 Work RVUs for 37227.**

707

37228 Revascularization, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty

The RUC reviewed the survey data from 74 cardiologists, vascular surgeons and radiologists for new bundled code, 37228. This code describes a service that was previously reported with the existing tibial peroneal angioplasty code (35470 = 8.62 RVUs) plus the existing radiological S&I code for balloon angioplasty (75962 = 0.54 RVUs) plus one catheterization code that would be used for this procedure, typically 36247 (3.15 RVUs after 50% multiple procedure reduction), resulting in 12.31 RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for the selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriate positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 61640 *Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel* (Work RVU=12.32). The RUC noted that the reference code has more total physician time in comparison to the surveyed code (227 minutes and 168 minutes, respectively). Further, the RUC noted that the reference code requires more technical skill, urgency of decision making and

overall is a more intense service to perform in comparison to the surveyed code. However, the specialty societies agreed that the median value of 12.00 over-estimated the amount of work for this service and did not maintain rank order between 37228 and 37226 *Revascularization, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s)*. The specialty societies explained that although 37228 and 37226 have the same total service time, they are performed in different vascular beds and as the vessels get smaller the intensity of the work is greater. Based on this explanation, 37228 should be valued higher than 37226. Therefore, the specialty societies agree that 11.00 Work RVUs, a value slightly less than the survey median, adequately reflects the work being performed and preserves the increment of work between 37226 and 37228. **The RUC recommends 11.00 Work RVUs for 37228.**

37229 Revascularization, tibial/peroneal artery, unilateral, initial vessel; with atherectomy

The RUC reviewed the survey data from 68 cardiologists, vascular surgeons and radiologists for new bundled code, 37229. This code describes a service that was previously reported with the existing stent code (35495 = 9.48 RVUs) plus the existing radiological S&I code for peripheral atherectomy. (75992 = 0.54 RVUs) plus the catheterization code that would be used for this procedure (36247 = 3.15 after 50% multiple procedure reduction), resulting in 13.17 RVUs. In addition, we believe many of today's providers will additionally report a balloon angioplasty and balloon angioplasty S&I during an iliac stent procedure (35470 = 4.31 RVUs after 50% multiple procedure reduction) plus the angioplasty S&I (75962 = 0.54), resulting in 18.02 Work RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for the selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriate positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 92980 *Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel* (Work RVU=14.82). The RUC noted that although the survey respondents indicated that the surveyed code was overall a more intense service to perform in comparison to 92980, the reference code has significantly more total physician time as compared to the surveyed code, 225 minutes and 198 minutes, respectively. Overall, 92980 is a good reference code as it describes, access, catheterization of a remote vascular bed (100-120 cm) with selection across stenoses of small caliber 2-4 mm vessels, followed by angioplasty and stent placement. However, the vessels and treatment zones are shorter in the coronary bed (92980), and longer in the tibial bed (37229) with same obligate catheter exchanges, long length guidewires, multiple and sometimes prolonged inflations of the angioplasty balloon, stent deployment, pressure measurements, and follow-up angiography, hence the survey median value for 37229 maintains proper rank order with 92980. Based on these comparisons to the reference code, the specialty societies recommend and the RUC agrees that the survey median, 14.05 RVUs, accurately reflects the work required to perform this service. **The RUC recommends 14.05 Work RVUs for 37229.**

37230 Revascularization, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s)
The RUC reviewed the survey data from 72 cardiologists, vascular surgeons and radiologists for new bundled code, 37230. This code describes a service that was previously reported with the existing stent code (37205 = 8.27 RVUs) plus the existing radiological S&I code for peripheral stent (75960 = 0.82 RVUs) plus selective catheterization (36247 = 3.15 RVUs after 50% multiple procedure reduction), resulting in 12.24 RVUs. In addition, we believe many of today's providers will additionally report a balloon angioplasty and balloon angioplasty S&I during a tibial stent procedure as stenting is often a bailout for failed angioplasty thus (35470 = 4.31 RVUs after 50% multiple procedure reduction) plus the angioplasty S&I (75962 = 0.54 RVUs), resulting in 17.09 RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for the selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriate positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 92980 *Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel* (Work RVU=14.82). The RUC noted that although the survey respondents indicated that the surveyed code was overall a more intense service to perform in comparison to 92980, the reference code has significantly more total physician time as compared to the surveyed code, 225 minutes and 195 minutes, respectively. Overall, 92980 is a good reference code as it describes, access, catheterization of a remote vascular bed (100-120 cm) with selection across stenoses of small caliber 2-4 mm vessels, followed by angioplasty and stent placement. However, the vessels and treatment zones are shorter in the coronary bed (92980), and longer in the tibial bed (37230) with same obligate catheter exchanges, long length guidewires, multiple and sometimes prolonged inflations of the angioplasty balloon, stent deployment, pressure measurements, and follow-up angiography, hence the survey median value for 37230 maintains proper rank order with 92980. Based on these comparisons to the reference code, the specialty societies recommend and the RUC agrees that the survey median, 13.80 RVUs, accurately reflects the work required to perform this service. **The RUC recommends 13.80 Work RVUs for 37230.**

709

37231 Revascularization, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy
The RUC reviewed the survey data from 67 cardiologists, radiologists and vascular surgeons for new bundled code, 37231. This code described a service that was previously reported with the existing atherectomy code 35495 = 9.48 RVUs reported with its radiological S&I code (75992 = 0.54 RVUs) in addition to the stent code (37205 = 4.14 RVUs after 50% multiple procedure reduction) plus the existing radiological S&I code for peripheral stent (75960 = 0.82 RVUs) plus the catheterization code (36247 = 3.15 RVUs after the

50% multiple procedure reduction), resulting in 18.13 RVUs. In addition, we believe many of today's providers will additionally report a balloon angioplasty and balloon angioplasty S&I during an iliac stent procedure (35473 = 3.02 RVUs after the 50% multiple procedure reduction) plus angioplasty S&I (75962 = 0.54 RVUs), resulting in 21.69 RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that 7 minutes of evaluation time was added to account for the selection and verification of numerous supplies and devices, review and set-up of significant imaging equipment, and the coordination of all technical staff. The 2 additional minutes of positioning time were added for appropriate positioning and securing the patient on the angiographic table including the placement of bolsters to protect the arms and placement of rulers underneath the patient to make sure that there is a reference for the physician during the deployment of the devices as well as other activities which are required in order to be able to obtain all necessary views to treat the lesion. The RUC compared this service to reference code 92980 *Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel* (Work RVU=14.82). The RUC noted that the surveyed code has more intra-service work as compared to the reference code, 135 minutes and 120 minutes, respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment, physical effort, and results in more psychological stress as compared to the surveyed code. Based on these comparisons to the reference code, the specialty societies recommend and the RUC agrees that the survey median, 15.00 RVUs, accurately reflects the work required to perform this service and maintains rank order with 37231. **The RUC recommends 15.00 Work RVUs for 37231.**

710

37232 Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty
The RUC reviewed the survey data from 64 cardiologists, vascular surgeons and radiologists for the new bundled code, 37232. This code describes a service that was previously reported with the existing tibial angioplasty code (35470 = 4.31 RVUs after 50% multiple procedure reduction) plus its radiological S&I code (75964 = 0.36 RVUs), plus the catheterization of each additional tibial artery (36248 = 1.01 RVUs), resulting in 5.68 RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that the additional minute of pre-service time represents the time required for the physician to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, the order to proceed, the approach to use and the impact the second site will have on the potential use of an embolic protection device. The specialty society explained that the additional minute of post-service time represents the additional time to review extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation. Additionally, more attention is required for the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion. The RUC understood that this was a rarely performed service when reviewing the surveyed code in comparison to the reference code 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel* (Work RVU=4.12). The RUC noted that the surveyed code had more intra-service time in comparison to the reference code, 40 minutes and 30 minutes,

respectively. The RUC also noted that the reference 34826 is analogous to the surveyed service. Intra-service time of the reference is less, but the work itself is similar to 37232 in that during an ongoing complex endovascular intervention (aortic endografting) an additional procedure is done with already existing catheters in place. Compared to placement of an aortic cuff, tibial intervention involves considerably more superselective catheter work (as opposed to nonselective placement of a stent-graft extension) with greater lengths of diseased vessel and longer catheters. Tibial intervention involve the complexity of multiple lesions treated with a greater possibility of distal embolization and/ or vascular occlusion. Based on these comparisons, the specialty societies agreed that the service should be valued higher than the reference code. However, the specialty societies explained that for this service it is much more difficult to deliver the first stent than the second stent. After reviewing the intensities of the base codes: 37228, 37230 and 37231, the specialty societies agreed that to maintain relativity with the base codes, 4.00 work RVUs, the survey's 25th percentile, accurately reflects the work required to perform the service. **The RUC recommends 4.00 Work RVUs for 37232.**

37233 Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy

The RUC reviewed the surveyed data from 58 cardiologists, radiologists and vascular surgeons for the new bundled code, 37233. This code describes a service that was previously reported with the existing tibial angioplasty and atherectomy codes (35470 = 4.31 RVUs after the 50% multiple procedure reduction) and the tibial atherectomy (35495 = 4.74 RVUs after the 50% multiple procedure reduction), reported with the PTA radiological S&I code (75964 = 0.36 RVUs) and additional peripheral atherectomy S&I code (75993 = 0.36 RVUs), plus the catheterization of each additional tibial artery would be reported (36248 = 1.01 RVUs), resulting in 10.78 RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that the additional minute of pre-service time represents the time required for the physician to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, the order to proceed, the approach to use and the impact the second site will have on the potential use of an embolic protection device. The specialty society explained that the additional minute of post-service time represents the additional time to review extra films and dictate extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation. Additionally, more attention is required for the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion. The RUC reviewed the surveyed code in comparison to the reference code 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel* (Work RVU=4.12). The RUC noted that the surveyed code has more intra-service time as compared to the reference code, 60 minutes and 30 minutes, respectively. Further, the RUC noted that the surveyed code required more mental effort and judgment, technical skill and physical effort to perform in comparison to the reference code. Based on these comparisons, the specialty societies agree that 6.50 work RVUs, the survey's median, accurately reflects the work required to perform the service. **The RUC recommends 6.50 Work RVUs for 37233.**

37234 Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s)
The RUC reviewed the survey data from 59 cardiologists, radiologists and vascular surgeons for the new bundled code, 37234. This code describes a service that was previously reported with the existing tibial angioplasty and stent codes (35470 = 4.31 RVUs after the 50% multiple procedure reduction), plus the additional intravascular stent (37206 = 4.12 RVUs) with the PTA radiological S&I code (75960 = 0.82 RVUs), plus the catheterization of each additional tibial artery would be reported (36248 = 1.01 RVUs) resulting in 10.26 RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that the additional minute of pre-service time represents the time required for the physician to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, the order to proceed, the approach to use and the impact the second site will have on the potential use of an embolic protection device. The specialty society explained that the additional minute of post-service time represents the additional time to review extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation. Additionally, more attention is required for the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion. The RUC reviewed the surveyed code in comparison to the reference code 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel* (Work RVU=4.12). The RUC noted that the surveyed code has more intra-service time as compared to the reference code, 60 minutes and 30 minutes, respectively. Further, the RUC noted that the surveyed code required more mental effort and judgment, technical skill and physical effort to perform in comparison to the reference code. Based on these comparisons, the specialty societies agree that 5.50 work RVUs, the survey's median, accurately reflects the work required to perform the service and maintains rank order with 37233 and 37235. **The RUC recommends 5.50 Work RVUs for 37234.**

712

37235 Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy
The RUC reviewed the survey data from 57 cardiologists, radiologists and vascular surgeons for the new bundled code, 37235. This code describes a service that was previously reported with the existing tibial atherectomy and stent codes (35470 tibial atherectomy = 4.74 RVUs after 50% multiple procedure reduction), the additional peripheral atherectomy S&I code (75993 = 0.36 RVUs), the additional intravascular stent code (37206 = 4.12 RVUs), the stent placement radiological S&I code (75960 = 0.82 RVUs), plus the catheterization of each additional tibial artery would be reported (36248 = 1.01 RVUs), resulting in 11.05 RVUs. The RUC agreed with the specialty societies' recommended physician time components for this service. The specialty society explained that the additional minute of pre-service time represents the time required for the physician to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, the order to proceed, the approach to use and the impact the second site will have on the potential use of an embolic protection device. The specialty society explained that the additional minute of post-service time represents the additional time to review extra films and dictating extra procedural details in the interpretation. Patients

with more than one treatment site require longer discussion and explanation. Additionally, more attention is required for the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion. The RUC reviewed the surveyed code in comparison to the reference code 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel* (Work RVU=4.12). The RUC noted that the surveyed code has more intra-service time as compared to the reference code, 60 minutes and 30 minutes, respectively. Further, the RUC noted that the surveyed code required more mental effort and judgment, technical skill and physical effort to perform in comparison to the reference code. Based on these comparisons, the specialty societies agree that 7.80 work RVUs, the survey's median, accurately reflects the work required to perform the service and maintains rank order with 37233 and 37234. **The RUC recommends 7.80 Work RVUs for 37235.**

Moderate Sedation: The RUC after reviewing the survey data for all of the endovascular revascularization procedures noted the moderate sedation was inherent. **Therefore, the RUC recommends that all of the endovascular revascularization procedures be added to Appendix G in the CPT 2011 Book and each code be designated with a ◎.**

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

713

Practice Expense
The RUC reviewed and accepted the practice expense inputs for 37220-37235 as approved by the PE Subcommittee.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
35301		Thrombendoarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision	090	19.61 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
+35306		each additional tibial or peroneal artery (List separately in addition to code for primary procedure) (Use 35306 in conjunction with 35305) (Do not report 35304, 35305, 35306 in conjunction with 35500, 35485,37229, 37231, 37233, 37235)	ZZZ	9.25 (No Change)
Transluminal Angioplasty				
35450		Transluminal balloon angioplasty, open; renal or other visceral artery	000	10.05 (No Change)
D 35454		~~iliac~~	000	N/A
D 35456		~~femoral-popliteal~~ (35454, 35456 have been deleted. To report, see 37220-37227)	000	N/A
D 35459		~~tibioperoneal trunk and branches~~ (35459 has been deleted. To report, see 37228-37235)	000	N/A
Percutaneous				
D 35470		~~Transluminal balloon angioplasty, percutaneous; tibioperoneal trunk or branches, each vessel~~ (35470 has been deleted. To report, see 37228-37235)	000	N/A

714

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
E 35471		Transluminal balloon angioplasty, percutaneous; renal or visceral artery	000	10.05 (No Change)
D 35473		~~iliac~~	000	N/A
D 35474		~~femoral-popliteal~~ (35473, 35474 have been deleted. To report, see 37220-37227)	000	N/A
Transluminal Atherectomy *If done as part of another operation, use modifier 51 or use modifier 52.* ~~(For radiological supervision and interpretation, see 75992-75996)~~ **Open**				
D 35480		~~Transluminal peripheral atherectomy, open; renal or other visceral artery~~ (35480 has been deleted. To report, see 0234T, 0235T)	000	N/A
D 35481		~~aortic~~ (35481 has been deleted. To report, use 0236T)	000	N/A
D 35482		~~iliac~~ (35482 has been deleted. To report, use 0238T)	000	N/A
D 35483		~~femoral-popliteal~~ (35483 has been deleted. To report, see 37225, 37227)	000	N/A

715

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 35484		~~brachiocephalic trunk or branches, each vessel~~ (35484 has been deleted. To report, use 0237T)	000	N/A
D 35485		~~tibioperoneal trunk and branches~~ (35485 has been deleted. To report, see 37229, 37231, 37233, 37235)	000	N/A
~~Percutaneous~~				
D 35490		~~Transluminal peripheral atherectomy, percutaneous; renal or other visceral artery~~ (35490 has been deleted. To report, see 0234T, 0235T)	000	N/A
D 35491		~~aortic~~ (35491 has been deleted. To report, use 0236T)	000	N/A
D 35492		~~iliac~~ (35492 has been deleted. To report, use 0238T)	000	N/A
D 35493		~~femoral-popliteal~~ (35493 has been deleted. To report, see 37225, 37227)	000	N/A
D 35494		~~brachiocephalic trunk or branches, each vessel~~ (35494 has been deleted. To report, use 0237T)	000	N/A
D 35495		~~tibioperoneal trunk and branches~~ (35495 has been deleted. To report, see 37229, 37231, 37233, 37235)	000	N/A

716

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Transcatheter Procedures Other Procedures				
▲37205	Z1	Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel *(For radiological supervision and interpretation, use 75960)* (For stent placement in iliac, femoral, popliteal, and tibial/peroneal arteries, see 37221, 37223, 37226, 37227, 37230, 37231, 37234, 37235) *(For coronary stent placement, see 92980, 92981; intracranial, use 61635)*	000	8.27 (No Changes) Specialty Society Request Review Postponement
+▲37206	Z2	each additional vessel (List separately in addition to code for primary procedure) (For stent placement in iliac, femoral, popliteal, and tibial/peroneal arteries, see 37221, 37223, 37226, 37227, 37230, 37231, 37234, 37235) (Use 37206 in conjunction with 37205) (For transcatheter placement of intravascular cervical carotid artery stent(s), see 37215, 37216) (For transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), see Category III codes 0075T, 0076T) (For radiological supervision and interpretation, use 75960)	ZZZ	4.12 (No Changes) Specialty Society Request Review Postponement

717

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲37207	Z3	Transcatheter placement of an intravascular stent(s) (non-coronary vessel other than iliac and lower extremity arteries), open; initial vessel (For stent placement in iliac, femoral, popliteal, and tibial/peroneal arteries, see 37221, 37223, 37226, 37227, 37230, 37231, 37234, 37235)	000	8.27 (No Changes) Specialty Society Request Review Postponement
+▲37208	Z4	each additional vessel (List separately in addition to code for primary procedure) (For stent placement in iliac, femoral, popliteal and tibial/peroneal arteries, see 37221, 37223, 37226, 37227, 37230, 37231, 37234, 37235) (Use 37208 in conjunction with 37207) (For radiological supervision and interpretation, use 75960) (For catheterizations, see 36215-36248) (For transcatheter placement of intracoronary stent(s), see 92980, 92981)	ZZZ	4.12 (No Changes) Specialty Society Request Review Postponement Meeting

Cardiovascular System
Endovascular Revascularization

Codes 37220-37235 are to be used to describe lower extremity endovascular revascularization services performed for occlusive disease. These lower extremity codes are built on progressive hierarchies with more intensive services inclusive of lesser intensive services. The code inclusive of all of the services provided for that vessel should be reported (ie, use the code inclusive of the most intensive services provided). Only one code from this family (37220-37235) should be reported for each lower extremity vessel treated.

These lower extremity endovascular revascularization codes all include the work of accessing and selectively catheterizing the vessel, traversing the lesion, radiological supervision and interpretation directly related to the intervention(s) performed, embolic protection

718

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
if used, closure of the arteriotomy by any method, and imaging performed to document completion of the intervention in addition to the intervention(s) performed. These codes describe endovascular procedures performed percutaneously and/or through an open surgical exposure. These codes include balloon angioplasty (eg, low-profile, cutting balloon, cryoplasty), atherectomy (eg, directional, rotational, laser), and stenting (eg, balloon-expandable, self-expanding, bare metal, covered, drug-eluting). Each code in this family (37220-37235) includes balloon angioplasty, when performed. These codes describe revascularization therapies (ie, transluminal angioplasty, atherectomy, and stent placement) provided in three arterial vascular territories: iliac, femoral/popliteal, and tibial/peroneal. 1. ***Iliac Vascular Territory***--The iliac territory is divided into 3 vessels: common iliac, internal iliac, and external iliac. 2. ***Femoral Popliteal Vascular Territory***--The entire femoral/popliteal territory in one lower extremity is considered a single vessel for CPT cod reporting. 3. ***Tibial/Peroneal Territory***--The tibial/peroneal territory is divided into three vessels: anterior tibial, posterior tibial and peroneal arteries. There are specific coding guidelines for each of the 3 vascular territories. 1. ***Iliac Vascular Territory*** -- A single primary code is used for the initial iliac artery treated in each leg (37220 or 37221). If other iliac vessels are also treated in that leg, these interventions are reported with the appropriate add-on code(s) (37222, 37223). Up to 2 add-on codes can be used in a unilateral iliac vascular territory since there are 3 vessels which could be treated. 2. **Femoral/Popliteal Territory**-- A single interventional code is used no matter what combination of PTA/stent/atherectomy is applied to all segments, including the common, deep and superficial femoral arteries as well as the popliteal artery (37224, 37225, 37226 or 37227). There are no add-on codes for additional vessels treated within the femoral/popliteal territory.			

719

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

3. **Tibial/Peroneal Territory**—A single primary code is used for the initial tibial/peroneal artery treated in each leg (37228, 37229, 37230, or 37231). If other tibial/peroneal vessels are also treated in the same leg, these interventions are reported with the appropriate add-on code(s) (37232-37235). Up to 2 add-on codes could be used to describe services provided in a single leg since there are 3 tibial/peroneal vessels which could be treated. The common tibio-peroneal trunk is considered part of the tibial/peroneal territory, but is not considered a separate, fourth segment of vessel in the tibio-peroneal family for CPT reporting. For instance, if lesions in the common tibio-peroneal trunk are treated in conjunction with lesions in the posterior tibial artery, a single code would be reported for treatment of this segment.

When treating multiple territories in the same leg, one primary lower extremity revascularization code is used for each territory treated. When additional vessel(s) are treated in the iliac and/or tibial/peroneal territories, add-on code(s) are used to report the additional service(s). When more than one stent is placed in the same vessel, the code should be reported only once.

720

When multiple vessels in multiple territories in a single leg are treated at the same setting, the primary code for the treatment in the initial vessel in each vascular territory is reported. Add-on code(s) are reported when second and third iliac or tibial/peroneal arteries are treated in addition to the initial vessel in that vascular territory.

If a lesion extends across the margins of one vessel vascular territory into another, but can be opened with a single therapy, this intervention should be reported with a single code despite treating more than one vessel and/or vascular territory. For instance, if a stenosis extends from the common iliac artery into the proximal external iliac artery, and a single stent is placed to open the entire lesion, this therapy should be coded as a single stent placement in the iliac artery (37221). In this example, a code for an additional vessel treatment would not be used (do not report both 37221 and 37223).

For bifurcation lesions distal to the common iliac origins which require therapy of 2 distinct branches of the iliac or tibial/peroneal vascular territories, a primary code and an add-on code would be used to describe the intervention. In the femoral/popliteal territory, all branches are included in the primary code, so treatment of a bifurcation lesion would be reported as a single code.

When both legs are treated in the same session, modifiers may be required to describe the bilateral interventions. If the same therapy is applied in the same vascular territory bilaterally, use 59 modifier. If different therapies are required to treat bilateral lesions in the

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
same vascular territories, these should be coded with 59 modifier to signify that bilateral therapies have been provided. However, if the therapy(s) are not in the same vascular territory in the contralateral leg, a modifier to denote opposite leg is not needed. Mechanical thrombectomy and/or thrombolysis in the lower extremity vessels are sometimes necessary to aid in restoring flow to areas of occlusive disease, and are reported separately.				
◎●37220	Z5	Revascularization, iliac artery, unilateral, initial vessel; with transluminal angioplasty	000	8.15
◎●37221	Z6	with transluminal stent placement(s)	000	10.00
◎+●37222	Z7	Revascularization, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure) (Use 37222 in conjunction with 37220, 37221)	ZZZ	3.73
◎+●37223	Z8	with transluminal stent placement(s) (List separately in addition to code for primary procedure) (Use 37223 in conjunction with 37221)	ZZZ	4.25
◎●37224	Z9	Revascularization, femoral/popliteal artery(s), unilateral; with transluminal angioplasty	000	9.00
◎●37225	Z10	with atherectomy	000	12.00
◎●37226	Z11	with transluminal stent placement(s)	000	10.49
◎●37227	Z12	with transluminal stent placement(s) and atherectomy	000	14.50

721

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
◎●37228	Z13	Revascularization, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty	000	11.00
◎●37229	Z14	with atherectomy	000	14.05
◎●37230	Z15	with transluminal stent placement(s)	000	13.80
◎●37231	Z16	with transluminal stent placement(s) and atherectomy	000	15.00
◎+●37232	Z17	Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure) (Use 37232 in conjunction with 37228-37231)	ZZZ	4.00
◎+●37233	Z18	with atherectomy (List separately in addition to code for primary procedure) (Use 37233 in conjunction with 37229-37231)	ZZZ	6.50
◎+●37234	Z19	with transluminal stent placement(s) (List separately in addition to code for primary procedure)	ZZZ	5.50
◎+●37235	Z20	with transluminal stent placement(s) and atherectomy (List separately in addition to code for primary procedure) (Use 37235 in conjunction with 37231)	ZZZ	7.80

722

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Radiology **Diagnostic Radiology (Diagnostic Imaging)** **Vascular Procedures** **Aorta and Arteries** *Selective vascular catheterizations …* *Additional second and/or …* The lower extremity endovascular revascularization codes describing services performed for occlusive disease (37220-37235) includes catheterization (36200, 36140, 36245-36248) in the work described by the codes. Catheterization codes are not additionally reported for diagnostic lower extremity angiography when performed through the same access site as the therapy (37220-37235) performed in the same session. However, catheterization for the diagnostic lower extremity angiogram may be coded separately if a different arterial puncture site is necessary. *For angiography performed …* *Diagnostic angiography (radiological supervision and interpretation) codes should NOT be used with interventional procedures for:* *1. Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the intervention,* *2. Vessel measurement, and* 3. Post-angioplasty/stent/atherectomy angiography, as this work is captured in the radiological supervision and interpretation code(s). In those therapeutic codes that include radiological supervision and interpretation, this work is captured in the therapeutic code. *Diagnostic angiography performed …*				

723

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		1. *No prior catheter-based ...* 2. A prior study is ...available, but as documented in the medical record: *a. The patient's condition ...* *b. There is inadequate ...* *c. There is a ...* Diagnostic angiography performed at a separate session ~~setting~~ from an interventional procedure is separately reported. If diagnostic angiography is necessary, is performed at the same session as the interventional procedure and meets the above criteria, a 59 modifier must be appended to the diagnostic radiological supervision and interpretation code(s) to denote that diagnostic work has been done following these guidelines. Diagnostic angiography performed at the time of an interventional procedure is NOT separately reportable if it is specifically included in the interventional code descriptor. (For intravenous procedure, see 36000, 36005-36015, and for intra-arterial procedure, see 36100-36248 ~~36000-36013, 36400-36245 and 36100-35248 for intra-arterial procedure~~) (For radiological supervision and interpretation, see 75600-~~75978~~75893) **Transcatheter Procedures**		
▲75960	Z21	Transcatheter introduction of intravascular stent(s) (except coronary, carotid, ~~and~~, iliac, and lower extremity artery), percutaneous and/or open,	XXX	0.82 (No Changes)

724

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		radiological supervision and interpretation, each vessel (For stent placement in iliac, femoral, popliteal, and tibial/peroneal arteries, see 37221, 37223, 37226, 37227, 37230, 37231, 37234, 37235)		Specialty Society Request Review Postponement
▲75962	Z22	Transluminal balloon angioplasty, peripheral artery other than iliac or lower extremity, radiological supervision and interpretation (For transluminal balloon angioplasty in iliac, femoral, popliteal, and tibial/peroneal arteries, see 37220-37235)	XXX	0.54 (No Changes) Specialty Society Request Review Postponement
+▲75964	Z23	Transluminal balloon angioplasty, each additional peripheral artery other than iliac and lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure) (For transluminal balloon angioplasty in iliac, femoral, popliteal, and tibial/peroneal arteries, see 37220-37235)	ZZZ	0.36 (No Changes) Specialty Society Request Review Postponement
Radiology **Diagnostic Radiology (Diagnostic Imaging)** ~~**Transluminal Atherectomy**~~				
D 75992		~~Transluminal atherectomy, peripheral artery, radiological supervision and interpretation~~ ~~(For procedure, see 35481-35485, 35491-35494)~~ (75992 has been deleted. To report, see 37225, 37227, 37229, 37231, 0238T)	XXX	N/A

725

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D +75993		~~Transluminal atherectomy, each additional peripheral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)~~ ~~(Use 75993 in conjunction with 75992)~~ ~~(For procedure, see 35481-35485, 35491-35495)~~ (75993 has been deleted. To report, see 37233, 37235, 0238T)	ZZZ	N/A
D 75994		~~Transluminal atherectomy, renal, radiological supervision and interpretation~~ ~~(For procedure, see 35480, 35490)~~ (75994 has been deleted. To report, use 0234T)	XXX	N/A
D 75995		~~Transluminal atherectomy, visceral, radiological supervision and interpretation~~ ~~(For procedure, see 35480, 35490)~~ (75995 has been deleted. To report, use 0235T)	XXX	N/A
D +75996		Transluminal atherectomy, each additional visceral artery, radiological supervision and interpretation (list separately in addition to code for primary procedure) (For procedure, see 35480, 35490) (Use 75996 in conjunction with 75995) (75996 has been deleted. To report, use 0235T)	ZZZ	N/A

726

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Category III **Atherectomy for Supra-Inguinal Arteries** Codes 0234T -0238T describe atherectomy performed by any method (~~et~~ eg, directional, rotational, laser) in arteries above the inguinal ligaments. These codes are structured differently than the codes describing atherectomy performed below the inguinal ligaments (37225, 37227, 37229, 37231, 37233, 37235). These supra-inguinal atherectomy codes all include the surgical work of performing the atherectomy plus the radiological supervision and interpretation of the atherectomy. Unlike the atherectomy codes for infra-inguinal arteries, this set of ~~Cat~~ Category III codes does not include accessing and selectively catheterizing the vessel, traversing the lesion, embolic protection if used, other intervention used to treat the same or other vessels, or closure of the arteriotomy by any method. These codes describe endovascular procedures performed percutaneously and/or through an open surgical exposure.				
●0234T		Transluminal peripheral atherectomy, including radiological supervision and interpretation; renal artery		N/A
●0235T		visceral artery (except renal), each vessel		N/A
●0236T		abdominal aorta		N/A
●0237T		brachiocephalic trunk and branches, each vessel,		N/A
●0238T		iliac artery, each vessel		N/A
0078T		Endovascular repair using prosthesis of abdominal aortic aneurysm, pseudoaneurysm or dissection, abdominal aorta involving visceral branches (superior mesenteric, celiac and/or renal artery[s]) (Do not report 0078T in conjunction with 34800-34805, 35081, 35102, 35452, ~~35454,~~ 35472, 37220-37223, 37205-37208)		N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(Report 0078T in conjunction with ~~35454,~~ 37220-37223, 37205-37208 when these procedures are performed outside the target zone of the endoprosthesis)		
✚0079T		Placement of visceral extension prosthesis for endovascular repair of abdominal aortic aneurysm involving visceral vessels, each visceral branch (List separately in addition to code for primary procedure) (Use 0079T in conjunction with 0078T) (Do not report 0079T in conjunction with 34800-34805, 35081, 35102, 35452, ~~35454,~~35472, 37220-37223, 37205-37208) (Report 0079T in conjunction with ~~35454,~~37220-37223, 37205-37208 when these procedures are performed outside the target zone of the endoprosthesis)		N/A
0080T		Endovascular repair of abdominal aortic aneurysm, pseudoaneurysm or dissection, abdominal aorta involving visceral vessels (superior mesenteric, celiac or renal), using fenestrated modular bifurcated prosthesis (2 docking limbs), radiological supervision and interpretation (Do not report 0080T in conjunction with 34800-34805, 35081, 35102, 35452, ~~35454,~~35472, 37220-37223, 37205-37208) (Report 0080T in conjunction with ~~35454,~~ 37220-37223, 37205-37208 when these procedures are performed outside the target zone of the endoprosthesis)		N/A

728

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
+0081T		Placement of visceral extension prosthesis for endovascular repair of abdominal aortic aneurysm involving visceral vessels, each visceral branch, radiological supervision and interpretation (List separately in addition to code for primary procedure) (Use 0081T in conjunction with 0080T) (Do not report 0081T in conjunction with 34800-34805, 35081, 35102, 35452, ~~35454,~~ 35472, 37220-37223, 37205-37208) (Report 0081T in conjunction with ~~35454,~~ 37220-37223, 37205-37208 when these procedures are performed outside the target zone of the endoprosthesis)		N/A

729

SIR**ACR**ACC**SCAI**SVS**

Working collaboratively to assure patient access to minimally invasive interventional procedures.

March 22, 2010

Barbara Levy, M.D.
Chair
AMA/Specialty Society Relative Value Update Committee
American Medical Association
515 N. State St.
Chicago, IL 60654

Dear Dr. Levy:

The Society of Interventional Radiology, American College of Radiology, Society for Vascular Surgery, American College of Cardiology, and Society for Cardiovascular Angiography & Interventions are currently coordinating and working diligently to survey across specialties, combine data, and submit recommendations in a timely fashion in order to meet the shortest RUC survey cycle timeframe for the 16 new CPT codes that will be used to report iliac and lower extremity revascularization. In addition to these 16 codes, each one of our societies has other simultaneous obligations for the April 2010 RUC meeting.

In reviewing the email received on March 4th regarding the finalized language provided for the Endovascular Revascularization issue, it came to our attention that the AMA staff included the revised transcatheter CPT codes 37205-37208 and 75960, 75962, 75964 as "revised" codes to be surveyed for the April 2010 RUC meeting. However, this was not the understanding of the multispecialty societies presenting the iliac and lower extremity revascularization code proposal at the February CPT Editorial Panel Meeting. Our societies believe it would be inappropriate to survey these codes at the present time, and we do not plan to do so for the following reasons:

1) There is no data to identify the "typical" application of these codes after iliac, femoral, popliteal and tibial applications of these codes are removed. The overwhelming majority of these 7 codes (37205-8, 75960, 75962, & 75964) are services that will soon be reported by the new codes that are under survey now. We estimate that reporting of the 7 codes in question will drop by as much as 90%. The typical patient for each of these codes will change as a result of the new iliac and lower extremity revascularization codes 372XX – 372X15, and it is not even certain what the typical patient will be.

2) The intravascular stent codes have already been identified through the "codes reported together 75% or more" screen and the affected societies have indicated a level 1 interest on the recent "CMS requests" LOI form. As such, action on them is anticipated.

We understand the RUC's desire to address this family of codes in an efficient manner by surveying them all at once. However, by definition, we will see a reduction in utilization of the existing stent code. Shifts will also be observed across ICD-9 codes and across specialties performing the services since the lower extremities are no longer part of the 37205 (stent) family. We believe that we should evaluate these shifts before we commit the current and future users of the code to re-survey. We do not know whether the stent code will be used mostly for the mesenteric vessels, renal vessels or brachiocephalic vessels, or perhaps none of these, yet those data would affect who we survey and the vignettes, descriptors and work recommendations we later provide.

Therefore, we respectfully request that the revised transcatheter codes (37205, 37206, 37207, 37208, 75960, 75962 & 75964) be removed from the list of CPT code for which surveys are expected at the April 2010 RUC Meeting. We agree that creation of new vignettes and performance of a full RUC survey for these 7 codes will be indicated once the family of new lower extremity interventional codes has been implemented and we have some idea of the volume and typical patient for the few remaining services that will be reported with the existing revised vascular stent CPT codes.

We greatly appreciate your review of this information and thank you for your time and attention to this matter.

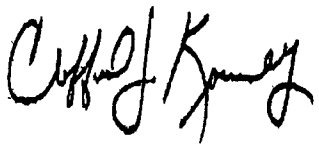
Sincerely,

Sean Tutton, MD
RUC Advisor
Society of Interventional Radiology

Geraldine McGinty, MD
RUC Advisor
American College of Radiology

Gary Seabrook, MD
RUC Advisor
Society of Vascular Surgery

Gregory S. Thomas, MD, MPH
RUC Advisor
American College of Cardiology



Clifford J. Kavinsky, MD
RUC Representative
Society for Cardiovascular Angiography & Interventions

Cc: Robert Vogelzang, MD, SIR
Gerald Niedzweicki, MD, SIR
Zeke Silva, MD, ACR
Sean Roddy, MD, SVS
Robert Zwolak, MD, SVS
Jenna Kappel, SIR RUC staff
Angela Kim, ACR RUC staff
Nancy Heath, SVS RUC staff
Brian Whitman, ACC RUC staff
Dawn Hopkins, SCAI RUC staff

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:37220 Tracking Number Z5 Specialty Society Recommended RVU: **8.15**
Global Period: 000 RUC Recommended RVU: **8.15**

CPT Descriptor: Revascularization, iliac artery, unilateral, initial vessel; with transluminal angioplasty

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57-year-old male smoker is seen for right buttock and calf claudication. Diagnostic studies show a focal concentric stenosis of the right common iliac artery.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

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

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

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

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

Moderate Sedation

, moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 92%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 64%

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

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Description of Pre-Service Work: Based on patient symptoms, signs, physical findings and pre-procedural studies, the physician estimates the range of guiding catheters, selective catheters, sheaths, guidewires, and balloons that may be required, and ensure availability. Additional physician work includes: assess need for stand-by devices that might be needed emergently (eg, stents and covered stents), review results of preadmission testing, with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Also, reexamine patient to make sure that physical findings have not changed and update H&P; discuss procedure detail plan, including alternatives and risks with patient and family. Obtain informed consent for procedure and conscious sedation. Mark access sites. Check interventional suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Ensure all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with all required devices. Ensure the patient is appropriately positioned on the table and intravenous access has been achieved. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Supervise sterile prep of access site(s) and subsequent draping. Perform pre-procedural "time-out."

escription of Intra-Service Work: Conscious sedation is administered and adequate conscious sedation monitoring is verified. A suitable access vessel is cannulated either percutaneously or with open exposure of the vessel, and a catheter and guidewire are manipulated into the diseased iliac artery using fluoroscopic guidance. Roadmapping images are obtained for vessel sizing and to document anatomy. The area of stenosis/occlusion is crossed with a guidewire, and a sheath is advanced to or through the stenosis/occlusion. An appropriately sized angioplasty balloon catheter is advanced to

the area of stenosis and is positioned using fluoroscopic guidance, and then is inflated to the appropriate pressure and time for opening of the lesion. The balloon is removed or pulled back over the wire, and follow-up images are obtained with contrast injection to determine if the stenosis has been adequately treated. Multiple balloon inflations may be required, or additional balloons with larger or smaller diameters may be used. If there are multiple segments of disease within the same iliac segment, these are also treated with appropriate-sized balloon(s). Once a satisfactory result has been documented the absence of extravasation or embolization, the embolic protection device is retrieved if used, the sheath is removed and hemostasis obtained with manual compression, closure device, or surgical closure of the arteriotomy.

Description of Post-Service Work: Apply sterile dressings. As needed, assist team in moving patient to stretcher. Discuss post-procedure care with recovery area staff. Write post-procedure orders for care and pain medication. Write brief procedure note. Record contrast volume and radiation exposure time. Review all films and dictate interpretation. Repeat patient exam and assessment of vital signs and perfusion of treated limb multiple times in recovery area, as needed. Monitor groin puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). Write orders for follow-up labs, x-rays. All appropriate medical records are completed, with copy to referring physician.

Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, x-rays, and patient care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010		
Presenter(s):	Joseph Babb, MD; David Han, MD; Clifford Kavinsky, MD; Arthur Lee, MD; Geraldine McGinty, MD; Gerald Niedzwiecki, MD; Gary Seabrook, MD; Mathew Sideman, MD; Zeke Silva, MD; Gregory Thomas, MD; Sean Tutton, MD; Robert Vogelzang, MD; Robert Zwolak, MD		
Specialty(s):	cardiology (ACC, SCAI); vascular surgery (SVS); radiology (ACR, SIR)		
CPT Code:	37220		
Sample Size:	600	**Resp N:** 129	**Response:** 21.5 %
Sample Type:	Random	**Additional Sample Information:** random and panel	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**11.00**	25.00	400.00
Survey RVW:	4.25	7.00	**8.15**	11.00	25.50
Pre-Service Evaluation Time:			**55.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	30.00	60.00	**60.00**	90.00	180.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**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:	37220	**Recommended Physician Work RVU: 8.15**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**33.00**	**7.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
36478	000	6.72	**RUC Time**

CPT Descriptor Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
31600	000	7.17	**RUC Time**	41,800

CPT Descriptor 1 Tracheostomy, planned (separate procedure);

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
58561	000	9.99	**RUC Time**	1,075

CPT Descriptor 2 Hysteroscopy, surgical; with removal of leiomyomata

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

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

Number of respondents who choose Key Reference Code: 19 **% of respondents:** 14.7 %

TIME ESTIMATES (Median)	**CPT Code: 37220**	**Key Reference CPT Code: 36478**	**Source of Time RUC Time**
Median Pre-Service Time	48.00	65.00	
Median Intra-Service Time	60.00	55.00	
Median Immediate Post-service Time	30.00	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	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	**138.00**	**154.00**
Other time if appropriate		

NTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.62	2.23
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.08	2.92
Urgency of medical decision making	2.54	2.08
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.15	2.85
Physical effort required	2.69	2.69
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.46	2.85
)utcome depends on the skill and judgment of physician	3.62	3.46
Estimated risk of malpractice suit with poor outcome	3.00	2.92

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.62	2.69
Intra-Service intensity/complexity	3.15	3.08
Post-Service intensity/complexity	2.62	2.46

Additional Rationale and Comments

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.*

Why is this Code Being Presented to the RUC?
The family of percutaneous interventional codes was identified by the RUC 5-Year Review Identification Workgroup for higher than anticipated increase in volume.

What is the "big picture" overview of this multiple code procedure?
The family of interventional procedures includes four possible treatment modalities (angioplasty, stenting, atherectomy, stenting plus atherectomy) that can be used in three arterial beds (iliac, femoropopliteal, tibial). This SoR represents angioplasty in the iliac arterial bed.

The New Codes Bundle selective catheterization, intervention and radiological S&I
Currently, all percutaneous vascular intervention procedures are reported with the component coding approach, meaning that at least, three codes are used to report each treatment at any single level in the arterial tree. The basic three codes currently include 1) a selective catheterization code, plus 2) a treatment code, plus 3) a radiological supervision and interpretation code. In contrast, the new codes in this family BUNDLE all three of these steps into a single code. Thus, new code 37220 will replace the use of, for example, 36245 (selective catheterization) plus 35473 (iliac angioplasty) plus 75962 (angioplasty S&I).

Pre-service Time has been Substantially Reduced From Survey Data
Patients requiring vascular intervention are typically older and have multiple medical co-morbidities. In order to have an iliac lesion sufficiently severe to require treatment the vignette patient probably has 50-100 pack-year of smoking, and he almost certainly has an element of coronary disease and COPD. These patients move slowly and require lots of TLC in order to obtain appropriate informed consent and accomplish all other pre-service tasks as well as conscious sedation. The survey respondents median pre-service evaluation time was 65 minutes with 10 minutes of scrub, dress and wait, for a total of 75 minutes. Our consensus panel voted to reduce the survey pre-time by 36% to 40 minutes of pre-service evaluation, 3 minutes of positioning, and 5 minutes of scrub, dress, wait. We recommend starting with pre-service package 2B. We believe it is fully justified to add 7 minutes to pre-service evaluation to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging necessary for the procedure, and to coordinate all technical personnel. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views to treat the lesion in question. These shorter pre-service times have been used in all the following comparisons with reference services.

Comparison with Key Reference Service 36478 – RVW 6.72
Key reference 36478 was chosen by 19 survey respondents. The service is "Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated". 36478 was evaluated by the RUC in February 2004. It is a 0-day global service, similar to the new code. 36478 has an RVW of 6.72, and it has an intra-service time of 55 minutes with intra-service work of 4.50. 36478 is a service performed on a symptomatic vein, which is a clinical situation with substantially less complexity and stress than working on a symptomatic artery. Thus, to estimate an RVW for the new service based on the RVW of the key reference, one must make an upward adjustment both for time and intensity. Adjustment for intra-time is 60/55 x 4.50 = 4.91. Adjustment for intensity includes a 26% increment for arterial complexity over vein complexity (justified by IWPUT 0.108 vs. 0 082), or 1.26 x 4.91 = 6.19. Overall, the additional intra-service work of 37220 compared to 36478 is 6.19-4.50 = 1.69. Adding 1.69 intra-service work increment to the 6.72 RVW of the key reference service results in 8.41. Thus, after making appropriate adjustments to the key reference service for the additional time and intensity involved 37220, the recommended RVW of 8.15 is well justified.

Comparison with MPC List Code 1, CPT 31600 – RVW 7.17
31600 "Tracheostomy, planned (separate procedure)" is a 0-day global procedure that was valued at 7.17 RVW by the RUC in August, 2000. This code has 50 minutes pre-time, 40 minutes intra-time, and 66 minutes post-time. The 40 minute intra-time of 31600 is 20 minutes less than that of new code 37220. To estimate an RVW for the new code based on the RVW of this MPC code, one needs to add value for the additional 20 minutes of intra-service time. A very conservative intensity for complex procedure work would be 0.090 RVUs/min so that would equate to an extra 1.8 RVUs. Thus, a work value for new code 37220 can calculated as 7.17 (value of MPC service) plus 1.80 RVUs (extra intra work) for a value of 8.97 work RVUs. In conclusion, comparison with this MPC service readily justifies the median survey value of 8.15 that we recommend for 37220.

Comparison with MPC List Code 2, CPT 58561 – RVW 9.99

A closely valued 0-day global MPC list service is 58561 "Hysteroscopy, surgical; with removal of leiomyomata" with an RVW of 9.99 compared to the 8.15 RVW we recommend for 37220. The RUC valued 58561 based on a survey demonstrating 40 minutes of pre-service time, which is slightly less than 37221 (48 min. pre). 58561 has 75 minutes of ıtra-service time, 15 min more than new code 37220 (60 min intra). Finally, both codes have 30 minutes of post-service time. Hysteroscopy involves entering and distending the endometrial cavity with subsequent removal of leiomyomata. Iliac angioplasty involves entering a major artery in the body with subsequent dilation exactly at the site of a hemodynamically significant stenosis. Both services are certainly intense and complex, probably of equal magnitude, but 37221 iliac angioplasty involves 15 less intra-service time. To estimate an RVW based on reference 58561 one can reduce intra-work by 15 min x 0.100 assumed IWPUT = -1.50 RVUs. Pre- and post- time and work are essentially a wash. Therefore, starting with the 9.99 RVW of 58561 and subtracting 1.50 for the intra-service adjustment, and estimated RVW of 9.99 – 1.50 = 8.49 can be determined for 37220. Thus, this MPC service comparison readily justifies the recommended median survey RVW of 8.15 for 37220.

Comparison with Other Angioplasty Codes in this Proposal

The recommended RVW for fem-pop angioplasty (37224) is 9.00. This is more than the 8.15 RVW we recommend for iliac angioplasty (37220). The increment of 0.85 RVUs is justified primarily by the additional intra-service time, 80 minutes for 37224 vs. 60 min. for 37220. The fem-pop approach is typically performed from the opposite groin by puncturing the common femoral artery, directing the catheter centrally towards the aorta, then selectively catheterizing the common iliac, the external iliac, the superficial femoral artery and finally the popliteal artery. This requires substantially more time than catheterization for the iliac artery angioplasty.

The recommended RVW for this fem-pop angioplasty procedure (9.00) is appropriately lower than that which recommend for tibial artery angioplasty (37228, RVW 12.00).

IWPUT

IWPUT of 37220 is 0.108 based in median survey time and the reduced pre-service time inputs we note above. This is a ʻypical IWPUT for high intensity percutaneous services that do not include lower intensity time periods of opening and losing that is associated with open surgical procedures.

How is Iliac Angioplasty Currently Reported and Valued?

Component coding is used currently to report this procedure. The primary procedure receives full RVU value while subsequent 0-, 10-, and 90-day global procedures receive a 50% multiple procedure payment reduction. XXX radiological supervision and interpretation codes are not subject to a multiple procedure payment reduction. The procedure that will soon be reported with 37220 is currently reported with the existing iliac angioplasty code (35473 @ 6.03 RVUs) plus the existing radiological S&I code for balloon angioplasty (75962 @ 0.54 RVUs) plus a catheterization code, either 36200, 36245 or 36246 for this procedure depending on the access site chosen and the exact target vessel. There are no extant data to determine the "typical" selective catheterization so the best estimate is to take an average of these three codes (4.32 RVUs) and reduce that value by 50% for the multiple procedure reduction (thus, 4.32 x 0.5=2.16)

Therefore, the typical current work RVUs for iliac angioplasty may be calculated as:

Iliac angioplasty		6.03
+ Radiologic S&I		0.54
+ Catheterization		2.16 (after multiple procedure reduction)
Total	=	8.73 RVUs as an estimate for typical iliac angioplasty case

Thus, our current median survey RVW recommendation of 8.15 for new code Z5 would represent all three of the above services and is substantially less than the current reimbursement.

ervices Reported with multiple CPT codes

The typical percutaneous iliac angioplasty will be reported with only one code, and that is why we checked "no" to the question below about services reported with multiple CPT codes. However, if the patient has not undergone a recent diagnostic angiographic exam, and if all other criteria for a diagnostic study were met, the appropriate diagnostic

arteriography code could be added (eg 75630). Likewise, providers who require ultrasound guidance to gain arterial access could also report CPT 76937 (RVW 0.30) as long as the meet the documentation requirements of that code.

Summary: We present a 129 person RUC survey with tightly clustered responses around the median RVW of 8.15. This RVW is supported by comparison to the key reference service (36478) and two MPC services (31600, 58561). The RVW recommendation is appropriate relative to the two other angioplasty services in this large submission, and IWPUT falls within the range of arterial intervention. Our recommendation is substantially lower than the estimate of current payment for this service. We believe the median survey value of 8.15 is the most accurate relative value recommendation for 37220.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 35473 75962 plus 36200, 36245 or 36246

How often do physicians 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 surgery	How often? Commonly
Specialty radiology	How often? Commonly

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. Unable to estimate National frequency.

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 13,298 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached table with estimated Medicare frequency.

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 37183

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:37221 Tracking Number Z6 Specialty Society Recommended RVU: **10.00**
Global Period: 000 RUC Recommended RVU: **10.00**

CPT Descriptor: Revascularization, iliac artery, unilateral, initial vessel; with transluminal stent placement(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57-year-old male smoker is seen for right buttock and calf claudication. Diagnostic studies show a complex, eccentric stenosis of the right common iliac artery. It is treated with a stent.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 92%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 62%

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

Description of Pre-Service Work: Based on patient symptoms, signs, physical findings and pre-procedural studies, the physician estimates the range of guiding catheters, selective catheters, sheaths, guidewires, balloons, and stents that may be required, and ensure availability. Physician work also includes the following. Assess need for stand-by devices that might be needed emergently (eg, covered stents). Review results of preadmission testing, with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Reexamine patient to make sure that physical findings have not changed and update H&P. Discuss procedure detail plan, including alternatives and risks with patient and family. Obtain informed consent for procedure and conscious sedation. Mark access sites. Check interventional suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Ensure all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with all required devices. Ensure the patient is appropriately positioned on the table and intravenous access has been achieved. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Supervise sterile prep of access site(s) and subsequent draping. Perform pre-procedural "time-out."

Description of Intra-Service Work: Conscious sedation is administered and adequate conscious sedation monitoring verified. A suitable access vessel is cannulated either percutaneously or with open exposure of the vessel, and a catheter and guidewire are manipulated into the diseased iliac artery using fluoroscopic guidance. Roadmapping images are obtained for vessel sizing and to document anatomy. The area of stenosis/occlusion is crossed with a guidewire, and a sheath is advanced to or through the stenosis/occlusion. The lesion may be initially treated with balloon angioplasty, either

as an intended primary therapy, or as pre-dilatation to allow passage of the stent delivery system. If the stent is intended as the primary therapy, an appropriately sized stent is selected and introduced to the lesion through the sheath. Using fluoroscopic guidance and appropriate road-mapping, the stent is positioned across the intended treatment zone, and is deployed, either by placement of a self-expanding stent or balloon-expandable stent. The stent may be seated or fully pened with additional ballooning. The stent delivery system and balloon are removed or pulled back over the wire, and follow-up images are obtained with contrast injection to determine if the stenosis has been adequately treated. Multiple balloon inflations may be required, or additional balloons with larger or smaller diameters may be used. If there are multiple segments of disease within the same iliac segment, these are also treated with appropriate-sized stent(s). Once a satisfactory result has been documented in the absence of extravasation or embolization, the embolic protection device is retrieved if used, the sheath is removed, and hemostasis obtained with manual compression, closure device, or surgical closure of the arteriotomy.

Description of Post-Service Work: Apply sterile dressings. As needed, assist team in moving patient to stretcher. Discuss post-procedure care with recovery area staff. Write post-procedure orders for care and pain medication. Write brief procedure note. Record contrast volume and radiation exposure time. Review all films and dictate interpretation. Repeat patient exam and assessment of vital signs and perfusion of treated limb multiple times in recovery area, as needed. Monitor groin puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). Write orders for follow-up labs, x-rays. All appropriate medical records are completed, with copy to referring physician.

Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, x-rays, and patient care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Joseph Babb, MD; David Han, MD; Clifford Kavinsky, MD; Arthur Lee, MD; Geraldine McGinty, MD; Gerald Niedzwiecki, MD; Gary Seabrook, MD; Mathew Sideman, MD; Zeke Silva, MD; Gregory Thomas, MD; Sean Tutton, MD; Robert Vogelzang, MD; Robert Zwolak, MD				
Specialty(s):	cardiology (ACC, SCAI); vascular surgery (SVS); radiology (ACR, SIR)				
CPT Code:	37221				
Sample Size:	600	**Resp N:**	126	**Response:** 21.0 %	
Sample Type:	Random	**Additional Sample Information:**	random and panel		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**20.00**	30.00	344.00
Survey RVW:	4.55	8.00	**10.00**	13.50	22.00
Pre-Service Evaluation Time:			**55.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**13.00**		
Intra-Service Time:	25.00	60.00	**90.00**	118.00	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:	**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:	37221	**Recommended Physician Work RVU: 10.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**33.00**	**7.00**
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:		**90.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 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
92980	000	14.82	**RUC Time**

CPT Descriptor Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
58561	000	9.99	**RUC Time**	1,075

CPT Descriptor 1 Hysteroscopy, surgical; with removal of leiomyomata

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	000	0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
37215	090	19.68	**RUC Time**

CPT Descriptor Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 26.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 37221**	**Key Reference CPT Code: 92980**	**Source of Time RUC Time**
Median Pre-Service Time	48.00	45.00	
Median Intra-Service Time	90.00	120.00	
Median Immediate Post-service Time	30.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Total Time	**168.00**	**225.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.65	3.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.65	3.65
Urgency of medical decision making	3.39	3.74
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.35	4.30
Physical effort required	3.65	3.78
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.87	3.91
Outcome depends on the skill and judgment of physician	4.30	4.30
Estimated risk of malpractice suit with poor outcome	3.91	4.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.35	3.35
Intra-Service intensity/complexity	4.17	4.17
Post-Service intensity/complexity	3.17	3.22

Additional Rationale and Comments

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

Why is this Code Being Presented to the RUC?
The family of percutaneous interventional codes was identified by the RUC 5-Year Review Identification Workgroup for higher than anticipated increase in volume.

What is the "big picture" overview of this multiple code procedure?
The family includes 4 possible treatment modalities (angioplasty, stenting, atherectomy, stenting plus atherectomy) that can be used in three arterial beds (iliac, femoropopliteal, tibial). This SoR represents stent placement in the iliac arterial bed.

The New Codes Bundle Selective Catheterization plus Intervention plus Radiologic Supervision & Interpretation
Currently, all percutaneous vascular intervention procedures are reported with the component coding approach, meaning that at least three codes are used to report each treatment at any single level in the arterial tree. The basic three codes for stenting currently include 1) a selective catheterization code, plus 2) a stent code, plus 3) a radiological supervision and interpretation code. In contrast, the new codes in this family BUNDLE all three of these steps into a single code. Thus, new code 37221 will replace the use of, at a minimum, a code such as 36245 (selective catheterization) plus 37205 (non-coronary stent) plus 75960 (peripheral stent S&I). However, many providers also report simultaneous balloon angioplasty on the same arterial segment during the same session. Thus, current reporting for this service could additionally include a balloon angioplasty code (eg 35473) and the S&I for the angioplasty (eg 75962). The new codes BUNDLE all angioplasty within the stent codes, thereby prohibiting simultaneous use of these additional angioplasty codes at this vessel.

How is Iliac Stent Currently Reported and Valued?
Component coding rules govern current reporting of this procedure. The primary procedure is assigned full RVW value while subsequent 0-, 10-, and 90-day global procedures receive a 50% multiple procedure payment reduction. XXX radiological supervision and interpretation codes are not subject to a multiple procedure payment reduction. The procedure that will soon be reported with 37221 is currently reported with the existing stent code (37205 @ 8.27 RVUs) plus the existing radiological S&I code for stent (75960 @ 0.82 RVUs) plus one catheterization code, either 36200, 36245 or 36246 depending on the access site chosen and the exact target vessel. There are no extant data to determine the typical selective catheterization so the best estimate is to take the average of these three (4.32 RVUs) and reduce it by 50% for multiple procedure reduction (thus, 2.16). In addition, many current providers additionally report a balloon angioplasty and angioplasty S&I code during an iliac stent procedure (balloon is 35473 @ 6.03 RVUs cut by 50% for multiple procedure = 3.02, and angioplasty S&I is 0.54)

Thus, a common current coding scenario could result in the following RVUs:

Iliac stent	8.27	
Stent S&I	0.82	
Iliac angioplasty	3.02	(after multiple procedure payment reduction)
Angioplasty S&I	0.54	
Catheterization	2.16	(after multiple procedure payment reduction)
Total =	14.81	RVUs that may be reported in 2010 for placement of an iliac stent.

Thus, our current median survey recommendation of 10.00 work RVUs for new code Z6 would represent a 32% reduction compared to this component coding example that uses current 2010 RVUs.

Pre-service Time has been Substantially Reduced From Survey Data
Patients requiring vascular intervention are typically older and have multiple medical co-morbidities. In order to have an iliac lesion sufficiently severe to require treatment, the vignette patient probably has 50-100 pack-year of smoking, and he almost certainly has an element of coronary disease and COPD. These patients move slowly and require lots of TLC in order to obtain appropriate informed consent and accomplish all other pre-service tasks as well as conscious sedation. The survey respondents median pre-service evaluation time was 65 minutes with 13 minutes of scrub, dress and wait, for a total of 78 minutes. Our consensus panel voted to reduce the survey pre-time by 36% to 40 minutes of pre-service evaluation time, 3 minutes of positioning time, and 5 minutes of scrub/dress/wait time. We recommend starting with pre-service package 2B. We believe it is fully justified to add 7 minutes to pre-service evaluation to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging necessary for the procedure, and to coordinate all technical personnel. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views to treat the lesion in question.

Comparison with Key Reference Service 92980 – RVW 14.82
The key reference code 92980 "Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel" was chosen by 33 respondents. 92980 is a 0-day global code valued by the RUC at 14.82 work RVUs. 92980 has 45 minutes of pre-service time compared to 48 minutes for the ne code, so that is essentially equivalent. 93980 has 120 minutes of intra-service time, exactly 30 minutes more than that of new code 37221, which has 90 minutes. Thus, a significant downward adjustment must be made for reduced intra-time if one is going to compare the two services. Finally, 92980 has 60 minutes of post-time compared to 30 minutes for the new code, so an adjustment must be mad there as well. So the analysis can be as follows.

Intra-service work of 92980 is 12.61 RVUs, and this must be reduced by 25% for the intra-service time difference, or -3.15 RVUs, down to 9.46 RVUs for intra-service work. Post-service work of 92980 is 1.34 RVUs, and this must be reduced by 50% to represent the new code, so this difference is 0.62 RVUs. Thus, the total reduction based on time adjustment is 3.15 + 0.62 = 3.77 RVUs that must be subtracted from the value of 92980 to approximate the value of the new code, or 14.82 – 3.77 = 11.05.

Based purely on time adjustments, the calculated value for 37221 would be 11.05. Although our survey respondents rated the complexity and intensity indicators of the new code to be essentially equivalent to that of 92980, our Consensus Panel concluded that iliac stent is less intense than coronary stent. In fact, the intensity as measured by IWPUT is 0.105 for 92980 coronary stent and 0.092 for 37221 iliac stent, or approximately a 10% reduction. Carving another 10% from the 9.46 intra-service RVUs for an intensity adjustment, would result in an additional -0.95 RVU reduction. Thus, the value of the new code adjusting only for time is 11.05. If we subtract another -0.95 for an intensity adjustment, the value of 37221 can be estimated as 11.05 – 0.95 = 10.10. Thus, adjusting Key Reference 92980 downward to account for less time and lower intensity clearly justifies the recommended median RVU of the new code, which is 10.00.

Comparison with MPC List CPT 58561 – RVW 9.99
The most closely valued MPC list service is 58561 "Hysteroscopy, surgical; with removal of leiomyomata" with a work RVU of 9.99 compared to the 10.00 RVUs we recommend for 37221. The RUC valued this service based on a survey demonstrating 40 minutes of pre-service time, which is slightly less than 37221 at 48 minutes. 58561 has 75 minutes of intra-service time, substantially less than new code 37221, that has 90 minutes intra-time. Finally, both codes have 30 minutes of post-service time. Hysteroscopy involves entering and distending the endometrial cavity with subsequent removal of leiomyomata. Iliac stent involves entering a major artery in the body with subsequent deployment of a metallic stent exactly at the site of a hemodynamically significant stenosis. Both services are certainly intense and complex, probably of equal magnitude, and 37221 iliac stent involves 15 additional minutes of intra-service time. With a work RVU of 9.99, this MPC service comparison readily justifies the recommended RVW of 10.00 for 37221.

Comparison with Clinically Relevant Service CPT 37215 Carotid Stent – RVW 19.68
Our Consensus Panel felt that CPT 37215 Carotid Stent placement would have been a perfect service to enter on the Reference Service List, save for the fact that it is a 90-day global service. We felt that survey respondents would not be able to perform the associated mathematics to carve away the post-service visits in order to derive an accurate comparison to the 0-day global service we are evaluating. However, the Consensus Panel can perform this math based on the RUC database, and then 37215 becomes an excellent service on which to assess the value of the new code.

37215 was valued by the RUC in 2004. It has an RVW of 19.68, and of this total, 4.51 RVUs derive from post-procedural visits that would not be part of a 0-day global. Thus, the 0-day comparison value of 37215 would be 19.68 – 4.51 = 15.07. The pre-service time of 37215 is 75 minutes evaluation plus 15 minutes SDW, together representing 1.80 RVUs. The pre-service time of 37221 is 43 min evaluation plus 5 min SDW, representing 1.00 RVUs, thus we need to subtract 0.80 RVUs from 15.07 to adjust for pre-time, or 15.07-0.80 = 14.23. Intra-service work of 37215 is 12.60 with an IWPUT of 0.122, while IWPUT of 37221 is 0.092. Intra-time of 37215 is 103 compared to 90 for 37221. Multiplying out the relative intra-time and intensity derives an intra-service work of 11.07 for 37221, or 4.30 RVUs lower than 37215. Thus, subtracting another 4.30 RVUs from 14.23 = 9.93

In summary, starting with 19.68 RVUs for the 90-day global service of 37215, we can estimate a relative value for 37221.

Begin with 37215 RVW of 19.68 and subtract 4.51 RVUs for post-op visits = 15.07. This reduces 37215 to a 0-day service.
Subtract 0.80 RVUs for the shorter pre-service time of 37221, = 14.23
Adjust intra-service work downward in consideration of relative time and intensity 14.23 – 4.30 = 9.93
Immediate post-service times are equivalent, so no adjustment
This relationship results in 9.93 RVUs for 37221, just at the recommended median survey of 10.00

Comparison with Clinically Relevant CPT 37182 Transvenous Intrahepatic Portosystemic Shunt (TIPS)
Another clinically relevant comparison is CPT 37182 TIPS, which was valued by the RUC in 2002. TIPS is a 0-day global service with RVW 16.97, comprised of 30 minutes pre-time (0.60 RVUs) plus 150 minutes intra-time (15.70 RVUs) and 30 minutes post-time (0.60 RVUs). The main adjustment to draw a valid comparison lies in intra-service work. 37221 is 60 minutes (40%) shorter, and approximately 10% less intense (IWPUT 0.105 for TIPS, 0.092 for 37221). Thus, the 40% time adjustment would reduce intra-service work to 9.42, and the 10% downward intensity adjustment would reduce 9.42 to 8.48, for a net reduction of 7.22 work RVUs during the intra-service period. Pre-service adjustment adds 0.40 back to 37221

In summary, starting with 16.97 work RVUs for the 0-day global service 37182, we can estimate the value for 37221 by removing 7.72 intra-service work RVUs and adding 0.40 RVUs for pre-service, for an estimated value of 9.65 RVUs for the new service. This clinically relevant comparison also serves to validate our recommendation of the median survey 10.00 RVUs for 37221.

IWPUT – Intensity Assessment
IWPUT of 37221 at the median survey recommended RVW is 0.092. This value is typical for complex intra-arterial work, both open and percutaneous. This IWPUT also lies well within the range of the current proposal and existing IWPUTS for vascular intervention. For example:

Service	RUC Year	IWPUT
36821 open wrist AV fistula	2008	0.083 (appropriately less than 37221)
37221 iliac stent	**New**	**0.092**
92980 Coronary stent	1994	0.105 (all following are appropriately higher than 37221)
37182 TIPS	2002	0.105
61640 Intracranial PTA	2005	0.106
37215 Carotid stent	2004	0.122

Services Reported with multiple CPT codes
The typical iliac stent will be reported with one code, and that is why we checked "no" to the question below about services reported with multiple CPT codes. However, if the patient has not undergone a recent diagnostic angiographic exam, and if all other criteria for a diagnostic study were met, the appropriate diagnostic arteriography code could be added (eg 75630) as long as the full requirements for a diagnostic study were met. Likewise, providers who require ultrasound guidance to gain arterial access could also report CPT 76937 (RVW 0.30) as long as the meet the documentation requirements of that code.

Summary: In conclusion, we provide a 126 person RUC survey with tightly clustered responses around the median RVW of 10.00. This RVW is fully supported by comparison to the key reference service coronary stent (92980) plus MPC procedure hysteroscopy (56581), plus carotid stent (37215), and TIPS (37182). The service has an IWPUT well within the range of other vascular procedures. Our recommendation is substantially lower than the best estimate of current payment for this service. **We believe the median survey value of 10.00 is the most accurate relative value recommendation for 37221.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37205, 36200, 36245, 36246, 75960

How often do physicians 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 vascular surgery How often? Commonly

Specialty radiology How often? Commonly

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. Unable to estimate National frequency.

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?
34,061 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached table with estimated Medicare frequency.

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 35471

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:37222 Tracking Number Z7 Specialty Society Recommended RVU: **4.50**
Global Period: ZZZ RUC Recommended RVU: **3.73**

CPT Descriptor: Revascularization, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old male diabetic smoker is seen for right buttock and calf claudication. Diagnostic studies show a tight focal stenosis in the mid right external iliac artery in addition to a significant stenosis in the common iliac artery. The common iliac stenosis is treated with a stent (coded separately), and the external iliac stenosis is treated with transluminal balloon angioplasty.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 95%

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? 59%

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

Description of Pre-Service Work: Patients who require interventional treatment at more than one site will obligatorily require an increment of additional pre-service evaluation work by the physician for completion of a thorough pre-procedural assessment. The physician needs to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, which order to proceed in, what approach to use, and what impact the second site will have on potential use of an embolic protection device.

Description of Intra-Service Work: This procedure would most commonly be performed through the access obtained for the base procedure. However, it could also be performed from a separate access, in which case a suitable access vessel is cannulated either percutaneously or with open exposure of the vessel, and a catheter and guidewire are manipulated into the diseased iliac artery using fluoroscopic guidance. Roadmapping images are obtained for vessel sizing and to document anatomy. The area of stenosis/occlusion is crossed with a guidewire, and a sheath is advanced to or through the stenosis/occlusion. An appropriately sized angioplasty balloon catheter is advanced to the area of stenosis and positioned using fluoroscopic guidance, and then is inflated to the appropriate pressure and time for opening of the lesion. The balloon is removed or pulled back over the wire, and follow-up images are obtained with contrast injection to determine if the stenosis has been adequately treated. Multiple balloon inflations may be required, or additional balloons with larger or smaller diameters may be used. If there are multiple segments of disease within the same iliac segment,

these are also treated with appropriate-sized balloon(s). Once a satisfactory result has been documented in the absence of extravasation or embolization, the embolic protection device is retrieved if used, the sheath is removed, and hemostasis obtained with manual compression, closure device, or surgical closure of the arteriotomy.

Description of Post-Service Work: Additional post-service work over and above that already provided for the primary procedure includes more time reviewing extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation to patient and family. More attention needs to be paid to the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Joseph Babb, MD; David Han, MD; Clifford Kavinsky, MD; Arthur Lee, MD; Geraldine McGinty, MD; Gerald Niedzwiecki, MD; Gary Seabrook, MD; Mathew Sideman, MD; Zeke Silva, MD; Gregory Thomas, MD; Sean Tutton, MD; Robert Vogelzang, MD; Robert Zwolak, MD				
Specialty(s):	cardiology (ACC, SCAI); vascular surgery (SVS); radiology (ACR, SIR)				
CPT Code:	37222				
Sample Size:	600	**Resp N:**	79	**Response:** 13.1 %	
Sample Type:	Random	**Additional Sample Information:**	random and panel		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	5.00	**12.00**	25.00	300.00
Survey RVW:	2.00	4.12	**4.50**	6.75	13.55
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	6.00	28.00	**40.00**	70.00	210.00

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: ZZZ Global Code

CPT Code:	37222	**Recommended Physician Work RVU: 4.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**1.00**	**0.00**	**1.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**40.00**		

Immediate Post Service-Time:	**1.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
34826	ZZZ	4.12	**RUC Time**

CPT Descriptor Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code for primary procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
22525	ZZZ	4.47	**RUC Time**	13,086

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

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
5600	ZZZ	4.94	**RUC Time**	3,597

CPT Descriptor 2 Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure (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: 23 **% of respondents:** 29.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 37222**	**Key Reference CPT Code: 34826**	**Source of Time RUC Time**
Median Pre-Service Time	1.00	0.00	
Median Intra-Service Time	40.00	30.00	
Median Immediate Post-service Time	1.00	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	**42.00**	**30.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.29	3.50
Urgency of medical decision making	2.86	3.14
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.71	3.64
Physical effort required	3.21	3.29
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.79	3.71
Outcome depends on the skill and judgment of physician	3.93	3.71
Estimated risk of malpractice suit with poor outcome	3.57	3.57

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.79	3.07
Intra-Service intensity/complexity	3.64	3.50
Post-Service intensity/complexity	2.79	2.79

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.*

Vhy is this Code Being Presented to the RUC?
The family of percutaneous interventional codes was identified by the RUC 5-Year Review Identification Workgroup for higher than anticipated increase in volume.

What is the "big picture" overview of this multiple code procedure?
The family includes four possible treatment modalities (angioplasty, stenting, atherectomy, stenting plus atherectomy) that can be used in three arterial beds (iliac, femoropopliteal, tibial). This SoR represents angioplasty of an additional ipsilateral artery within the iliac bed.

The New Codes Bundle Selective Catheterization, Intervention and Radiological S&I
Currently, all percutaneous vascular interventions are reported with the component coding approach, meaning that separate codes are reported for selective catheterization, intervention, and radiological supervision and interpretation. In contrast, the new codes in this family BUNDLE these aspects of the service.

Why is an Add-On Code required in this proposal?
The iliac arterial bed has three distinct vessels, the common iliac artery, the external iliac artery, and the internal iliac artery. Most commonly only one of these three vessels would be treated, and a single primary code would be used to report that work. In the less common clinical situation in which more than one ipsilateral iliac vessel requires treatment, the appropriate iliac add-on code, i.e. 37222 (tracking number Z7) would be used.

Pre-service Time
Patients who require interventional treatment at more than one site will obligatorily require an increment of additional pre-service evaluation work by the physician for completion of a thorough pre-procedural assessment. The physician needs to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, which rder to proceed in, what approach to use, and what impact the second site will have on potential use of an embolic protection device. The median survey pre-time was 15 minutes. Our expert Consensus Panel reviewed the extra work that must be done, and the ultimate recommendation is 1 minute rather than 15.

Post-service Time
There is a small but real amount of additional post-service work above and beyond that already provided for the primary procedure includes more time reviewing extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation to patient and family. More attention needs to be paid to the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion. The median survey immediate post time was 15 minutes. Our expert Consensus Panel reviewed the extra work that must be done, and the ultimate recommendation is 1 minute rather than 15.

Comparison with Key Reference Service CPT 34826 – RVW 4.12
Key reference 34826 is an add-on code used to report placement of a proximal or distal endovascular extension stent graft during endovascular aneurysm repair. It has an intra-service time of 30 minutes and an RVW of 4.12. The median service time of new code 37222 is 40 minutes. Mathematical adjustment for the extra 10 minutes of intra-service time argues for 40/30 x 4.12 = 5.49 RVW based purely on time, assuming the intensity of the two are equal. However, the Consensus Panel agreed that the Key Reference is slightly more intense that the new code, so a relative reduction in intensity would bring the new code back down towards its median survey value of 4.50.

Comparison with MPC Code: CPT 22525 – RVW 4.47
CPT 22525 is an add-on zzz code used to report each additional level of percutaneous vertebral augmentation. It was valued by the RUC in 2005. This MPC reference has 40 minutes of intra-time, which is the same as the new code. Both ·ocedures are percutaneous and high intensity, the MPC reference representing work in the spine, while 37222 involves work within the iliac artery. This is nearly a perfect relative value reference and fully justifies the recommended RVW of 4.50.

Comparison with MPC Code : CPT 35600 – RVW 4.94

CPT 35600 is an add-on zzz code used to report harvest of a segment of upper extremity artery to be used during a coronary bypass graft. It has an intra-time of 40 minutes. This is an open surgical procedure so it lacks the clinical similarity of the 22525 comparison, but it is familiar to and performed by vascular surgeons. Therefore, in this circumstance it serves as an appropriate relative value comparison. 35600 represents 40 minutes of pure, high-intensity intra-service work, and 37222 represents 40 minutes of pure, high-intensity intra-service work. It stands to reason that the relative values of these two should be essentially equal, and with an RVW of 4.94, 35600 readily lends credence to our recommendation of the median survey RVW of 4.50 for 37222.

IWPUT Intensity

IWPUT of 37222 is 0.111 at the median survey RVW. This calculated intensity level lies well within the range of the current proposal and existing IWPUTS for high intensity zzz services that do not include lower intensity time periods of opening and closing.

ZZZ Add-on Service	RUC Year	IWPUT
37222 add-on angioplasty	**current SoR**	**0.111**
22525 MPC	2005	0.112
35600 MPC	2000	0.124
34826 Key Reference	2002	0.137

Summary: In conclusion, we provide a 79 person RUC survey with tightly clustered responses around the median RVW of 4.50. This RVW is fully supported by detailed comparisons to RUC-surveyed key reference service 34826 plus the MPC procedures 22525 and 35600. The recommended RVW fits appropriately within this family of codes, and the service has an IWPUT well within the range of other zzz add-on services. We believe the median survey value of 4.50 is the most accurate relative value recommendation for 37222.

SERVICES REPORTED WITH MULTIPLE 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. Primary iliac antioplasty code 372XX (tracking Z5) with recommended RVW of 8.15, global period 0-day, time elements 48/60/30 would be the typical parent code reported with 372X2 (tracking Z7) add-on. Since Z7 is a zzz code there will be no multiple procedure payment reduction. When these two procedures are reported together in patient undergoing multiple site iliac intervention, the total recommended RVW would be 12.65 with a total time of 49/100/31.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 35473 plus 75962

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

Specialty cardiology How often? Commonly

Specialty surgery How often? Commonly

Specialty radiology How often? Commonly

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. Unable to estimate National frequency.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,649
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached table with estimated Medicare frequency.

Specialty Frequency Percentage 0.00 %

pecialty 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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 35685

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:37223 Tracking Number Z8 Specialty Society Recommended RVU: **4.25**
Global Period: ZZZ RUC Recommended RVU: **4.25**

CPT Descriptor: Revascularization, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s) (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52-year-old female with history of smoking is evaluated for claudication of the right calf which occurs at ½ block. Diagnostic testing shows focal stenoses in the right common and external iliac arteries. Both are treated with stents. The RCIA treatment (initial vessel) is coded separately (3720X1).

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 95%

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? .58

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: Patients who require interventional treatment at more than one site will obligatorily require an increment of additional pre-service evaluation work by the physician for completion of a thorough pre-procedural assessment. The physician needs to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, which order to proceed in, what approach to use, and what impact the second site will have on potential use of an embolic protection device.

Description of Intra-Service Work: This procedure may be performed through the same access as that used for the base code procedure (372X2), or may require access through a separate entry site. A sheath is placed at the entry vessel, and the iliac artery to be treated is accessed. Imaging is performed with contrast injection to determine the size of the vessel and to document anatomy, and the lesion is crossed with a wire. The lesion may be primarily stented or secondarily stented following balloon angioplasty (angioplasty associated with this stent is NOT separately reportable). The appropriate stent is positioned across the lesion and deployed, and then may require further ballooning (not separately reportable) to achieve adequate opening of the vessel. If other segments of the same iliac artery are also stenosed or occluded, they may also b treated with additional stents and/or balloon angioplasty (work in the same iliac artery is not separately reportable). Imaging is performed to document that the vessel has been opened. Once a satisfactory result has been achieved in the absence of extravasation or embolization, the embolic protection device is retrieved if used, the sheath is removed, and hemostasis obtained with manual compression, closure device, or surgical closure of the arteriotomy.

Description of Post-Service Work: Additional post-service work over and above that already provided for the primary procedure includes more time reviewing extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation to patient and family. More attention needs to e paid to the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Joseph Babb, MD; David Han, MD; Clifford Kavinsky, MD; Arthur Lee, MD; Geraldine McGinty, MD; Gerald Niedzwiecki, MD; Gary Seabrook, MD; Mathew Sideman, MD; Zeke Silva, MD; Gregory Thomas, MD; Sean Tutton, MD; Robert Vogelzang, MD; Robert Zwolak, MD				
Specialty(s):	cardiology (ACC, SCAI); vascular surgery (SVS); radiology (ACR, SIR)				
CPT Code:	37223				
Sample Size:	600	**Resp N:**	79	**Response:** 13.1 %	
Sample Type:	Random	**Additional Sample Information:** random and panel			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	7.00	**15.00**	25.00	200.00
Survey RVW:	2.00	4.25	**5.00**	8.00	13.00
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**	90.00	240.00

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: ZZZ Global Code

CPT Code:	37223	**Recommended Physician Work RVU: 4.25**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**1.00**	**0.00**	**1.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**1.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
34826	ZZZ	4.12	**RUC Time**

CPT Descriptor Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code 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
35600	ZZZ	4.94	**RUC Time**	3,597

CPT Descriptor 1 Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63295	ZZZ	5.25	**RUC Time**	31

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

Other Reference CPT Code	Global	Work RVU	Time Source
22525	ZZZ	4.47	**RUC Time**

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

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 27.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 37223**	**Key Reference CPT Code:** 34826	**Source of Time** RUC Time
Median Pre-Service Time	1.00	0.00	
Median Intra-Service Time	45.00	30.00	
Median Immediate Post-service Time	1.00	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	**47.00**	**30.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.27	3.33
Urgency of medical decision making	3.07	3.07
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.73	3.73
Physical effort required	3.20	3.27
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.80	3.53
Outcome depends on the skill and judgment of physician	4.00	3.80
Estimated risk of malpractice suit with poor outcome	3.87	4.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.53	2.73
Intra-Service intensity/complexity	4.00	3.80
Post-Service intensity/complexity	2.47	2.60

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.*

Vhy is this Code Being Presented to the RUC?

The family of percutaneous interventional codes was identified by the RUC 5-Year Review Identification Workgroup for higher than anticipated increase in volume.

What is the "big picture" overview of this multiple code procedure?

The family includes four possible treatment modalities (angioplasty, stenting, atherectomy, stenting plus atherectomy) that can be used in three arterial beds (iliac, femoropopliteal, tibial). This SoR represents stent placement in an additional ispilateral iliac artery following treatment of an initial ipsilateral iliac vessel.

The New Codes Bundle Selective Catheterization, Intervention and Radiological S&I

Currently, all percutaneous vascular interventions are reported with the component coding approach, meaning that separate codes are reported for selective catheterization, intervention, and radiological supervision and interpretation. In contrast, the new codes in this family BUNDLE these aspects of the service. Specifically, this new code 37223 represents a stent placement including radiological S&I and catheter manipulation to deploy the stent. The only exception to catheter bundling would be if a completely separate puncture site were necessary to deploy this ipsilateral iliac stent, a very unlikely event.

Why is an Add-On Code required in this proposal?

The iliac arterial bed has three distinct vessels, the common iliac artery, the external iliac artery, and the internal iliac artery. Most commonly only one of these three vessels would be treated, and a single primary code would be used to report that work. In the less common clinical situation in which more than one ipsilateral iliac vessel requires treatment, this iliac stent add-on code, 37222 (tracking number Z8) would be reported.

Pre-service Time

atients who require interventional treatment at more than one site will obligatorily require an increment of additional pre-service evaluation work by the physician for completion of a thorough pre-procedural assessment. The physician needs to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, which order to proceed in, what approach to use, and what impact the second site will have on potential use of an embolic protection device. The median survey pre-time was 15 minutes. Our expert Consensus Panel reviewed the extra work that must be done, and the ultimate recommendation is 5 minutes rather than 15.

Post-service Time

There is a small but real amount of additional post-service work above and beyond that already provided for the primary procedure includes more time reviewing extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation to patient and family. More attention needs to be paid to the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion. The median survey immediate post time was 15 minutes. Our expert Consensus Panel reviewed the extra work that must be done, and the ultimate recommendation is 1 minute rather than 15.

Comparison with Key Reference Service CPT 34826 – RVW 4.12

Key reference 34826 is an add-on code used to report placement of a proximal or distal endovascular extension stent graft during endovascular aneurysm repair. Thus, there is distinct clinical similarity between the key reference and 37223 since both represent deployment of a type of intravascular device. 34826 has an intra-service time of 30 minutes and an RVW of 4.12. The median service time of new code 37223 is 45 minutes. Mathematical adjustment for the extra 15 minutes of intra-service time argues for 45/30 x 4.12 = 6.18 RVW based purely on time, assuming the intensity of the two are equal. However, the Consensus Panel agreed that the Key Reference is slightly more intense that the new code, so a relative reduction in intensity would bring the new code back down towards its median survey value of 5.00.

Comparison with MPC List Code 1: CPT 35600 – RVW 4.94
CPT 35600 is an add-on zzz code used to report harvest of a segment of upper extremity artery to be used during a coronary bypass graft. It has an intra-time of 40 minutes. This is an open surgical procedure so it lacks direct clinical similarity, but it is familiar to and performed by vascular surgeons, so in this circumstance 35600 serves as an appropriate relative value comparator. 35600 represents 40 minutes of pure, high-intensity intra-service work, and 37223 represents 4 minutes of pure, high-intensity intra-service work. It stands to reason that the relative value of the new code should be greater than that of the reference since the new code has 50% more intra-service time. With an RVW of 4.94, CPT 35600 readily serves to justify our recommendation of the median survey RVW of 5.00 for 37223.

Comparison with MPC List Code 2: CPT 63295 – RVW 5.25
CPT 63295 is an open spine procedure add-on code that was considered by the RUC in 2004. The clinical relationship to 37223 is the fact that both services are high intensity steps that occur in the midst of a complex primary service. The time comparison of MPC 63295 to 37223 is excellent. 63295 has 10 min. pre-service and 45 min. intra-service. This is nearly identical to 37223, which has 5 min pre-, 45 min intra-, 1 min post-service. Thus, the only difference between these two services is 4 min of additional pre/post time for the reference service. This comparison therefore serves as a strong justification for an RVW of 5.00 for the new service when the RUC-approved reference service has an RVW of 5.25.

Other Reference CPT Code: CPT 22525 – RVW 4.47
CPT 22525 is an add-on zzz code used to report each additional level of percutaneous vertebral augmentation. It was valued by the RUC in 2005. This reference (which is also an MPC code) has 40 minutes of intra-time, which is 5 min less than the new code. Both procedures are percutaneous and high intensity, 22525 representing work in the spine, while 37223 involves work within the iliac artery. To derive an RVW estimate for 37223 from 22525 one needs only to adjust for the additional intra-service time, or 45/40 x 4.47 = 5.03. Therefore, this is a third MPC reference that justifies an RVW of 5.00 for 37223.

How is an additional Iliac Stent Currently Reported and Valued?
Component coding is used currently to report this procedure that would be reported with ZZZ add-on stent code 37206 and its associated S&I code 75960. XXX radiological S&I codes are not subject to a multiple procedure payment reduction. Some providers will report only these two codes, while others will additionally report a balloon angioplasty and its associated S&I code

Thus, the minimal provider will currently report 4.12 RVUs (37206) plus 0.82 (75960) for a total of 4.94 RVUs. Other providers will report 4.12 (37206) + 0.82 (75960) + 3.02 (angioplasty after 50% reduction) + 0.54 (angioplasty S&I), for a total of 8.50.

There is no way to tell with certainty the proportion of providers who report an additional iliac stent without vs. with simultaneous balloon angioplasty, but with the new CPT codes all angioplasty of the vessel is inherent in the stent code. Thus, the current recommendation of 5.0 RVW for 37223 would essentially lock down the work value at the lowest end of the currently reported range, and this would be 41% less than what can now be reported.

IWPUT – Intensity
IWPUT of 37223 is 0.110 at the median survey RVW. This calculated intensity level lies well within the range of the current proposal and existing IWPUTS for high intensity zzz services that do not include lower intensity time periods of opening and closing.

Service	IWPUT
37223 at median survey	0.110
34826 Key Reference	0.137
35600 MPC Comparison 1	0.124
63295 MPC Comparison 2	0.112
22525 MPC Comparison 3	0.112

Summary: In conclusion, we provide a 79 person RUC survey with tightly clustered responses around the median RVW of 5.00. This RVW is fully supported by detailed comparisons to RUC-surveyed key reference service 34826 plus the MPC procedures 22525, 63295 and 35600. The recommended RVW fits appropriately within this family of

codes, and the service has an IWPUT well within the range of other zzz add-on services. We believe the median survey value of 5.00 is the most accurate relative value recommendation for 37223.

ERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Z6 + Z8

FREQUENCY INFORMATION

.low was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37206 or 37208

How often do physicians 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 surgery How often? Commonly

Specialty radiology How often? Commonly

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. Unable to estimate National frequency.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

`stimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,084
.f this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached table with estimated Medicare frequency.

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 35685

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:37224 Tracking Number Z9 Specialty Society Recommended RVU: **9.00**
Global Period: 000 RUC Recommended RVU: **9.00**

CPT Descriptor: Revascularization, femoral/popliteal artery(s), unilateral; with transluminal angioplasty

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58-year-old female is evaluated for right leg claudication that develops at 2 blocks. Diagnostic testing reveals a segment of tandem short, focal stenoses of the mid to distal right superficial femoral artery. These are treated with balloon angioplasty.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 91%

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? 61%

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: Based on patient symptoms, signs, physical findings and pre-procedural studies, estimate the range of guiding catheters, selective catheters, sheaths, guidewires, and balloons that may be required, and ensure availability. Assess need for stand-by devices that might be needed emergently (eg, stents and covered stents). Review results of preadmission testing, with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Reexamine patient to make sure that physical findings have not changed and update H&P. Discuss procedure detail plan, including alternatives and risks with patient and family. Obtain informed consent for procedure and conscious sedation. Mark access sites. Check interventional suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Ensure all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with all required devices. Ensure the patient is appropriately positioned on the table and intravenous access has been achieved. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Supervise sterile prep of access site(s) and subsequent draping. Perform pre-procedural "time-out."

Description of Intra-Service Work: Conscious sedation is administered and adequate conscious sedation monitoring is verified. A suitable access vessel is cannulated either percutaneously or with open exposure of the vessel, and a catheter and guidewire are manipulated into the diseased femoral artery using fluoroscopic guidance. Roadmapping images are obtained for vessel sizing and to document anatomy. The area(s) of stenosis/occlusion is crossed with a guidewire, and a sheath is advanced to the stenosis/occlusion. An appropriately sized balloon angioplasty catheter is advanced to the area of

stenosis and is positioned using fluoroscopic guidance, and then is inflated to the appropriate pressure and time for opening of the lesion. The balloon is removed or pulled back over the wire, and follow-up images are obtained with contrast injection to determine if the stenosis has been adequately treated. Multiple balloon inflations may be required, or additional balloons with larger or smaller diameters may be used. If there are multiple segments of disease in the femoral artery segments in this leg, they are also treated with the appropriate size balloon or balloons. Once a satisfactory resu has been documented in the absence of extravasation or embolization, the embolic protection device is retrieved if used, th sheath is removed, and hemostasis obtained with manual compression, closure device, or surgical closure of the arteriotomy.

Description of Post-Service Work: Apply sterile dressings. As needed, assist team in moving patient to stretcher. Discuss post-procedure care with recovery area staff. Write post-procedure orders for care and pain medication. Write brief procedure note. Record contrast volume and radiation exposure time. Review all films and dictate interpretation. Repeat patient exam and assessment of vital signs and perfusion of treated limb multiple times in recovery area, as needed. Monitor groin puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). Write orders for follow-up labs, x-rays. All appropriate medical records are completed, with copy to referring physician.

Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, x-rays, and patient care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Joseph Babb, MD; David Han, MD; Clifford Kavinsky, MD; Arthur Lee, MD; Geraldine McGinty, MD; Gerald Niedzwiecki, MD; Gary Seabrook, MD; Mathew Sideman, MD; Zeke Silva, MD; Gregory Thomas, MD; Sean Tutton, MD; Robert Vogelzang, MD; Robert Zwolak, MD				
Specialty(s):	cardiology (ACC, SCAI); vascular surgery (SVS); radiology (ACR, SIR)				
CPT Code:	37224				
Sample Size:	600	**Resp N:**	89	**Response:** 14.8 %	
Sample Type:	Random	**Additional Sample Information:** random and panel			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**12.00**	25.00	150.00
Survey RVW:	4.40	7.99	**9.00**	12.00	20.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	40.00	60.00	**80.00**	100.00	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):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
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**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 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:	37224	**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:		**40.00**	**33.00**	**7.00**
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:		**80.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
ther 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
61640	000	12.32	**RUC Time**

CPT Descriptor Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
43269	000	8.20	**RUC Time**	18,220

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

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
58561	000	9.99	**RUC Time**	1,075

CPT Descriptor 2 Hysteroscopy, surgical; with removal of leiomyomata

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:** 15.7 %

TIME ESTIMATES (Median)	CPT Code: 37224	Key Reference CPT Code: 61640	Source of Time RUC Time
Median Pre-Service Time	48.00	77.00	
Median Intra-Service Time	80.00	90.00	
Median Immediate Post-service Time	30.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	**158.00**	**227.00**
Other time if appropriate		

NTENSITY/COMPLEXITY MEASURES (Mean)

		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.40	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.40	3.20
Urgency of medical decision making	3.60	3.60
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.40	4.40
Physical effort required	4.00	3.60
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.20	4.20
Outcome depends on the skill and judgment of physician	4.20	4.20
Estimated risk of malpractice suit with poor outcome	4.20	4.20

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.20	3.20
Intra-Service intensity/complexity	4.00	4.00
Post-Service intensity/complexity	3.60	3.60

Additional Rationale and Comments

escribe 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 Recommendations for the appropriate formula and format.*

Why is this Code Being Presented to the RUC?

The family of percutaneous interventional codes was identified by the RUC 5-Year Review Identification Workgroup for higher than anticipated increase in volume.

What is the "big picture" overview of this multiple code procedure?
The family includes four possible treatment modalities (angioplasty, stenting, atherectomy, stenting plus atherectomy) that can be used in three arterial beds (iliac, femoropopliteal, tibial). This SoR represents angioplasty in the femoropopliteal arterial bed.

The New Codes Bundle selective catheterization, intervention and radiological S&I
Currently, all percutaneous vascular intervention procedures are reported with the component coding approach, meaning that at least, three codes are used to report each treatment at any single level in the arterial tree. The basic three codes currently include 1) a selective catheterization code, plus 2) a treatment code, and 3) a radiological supervision and interpretation code. In contrast, the new codes in this family BUNDLE all three of these steps into a single code. Thus, new code 37224 will REPLACE the use of, for example, 36247 (selective catheterization) plus 35474 (fem-pop angioplasty) plus 75962 (angioplasty S&I).

Are there Add-On Codes in this arterial territory?
The femoropopliteal arterial system was considered by CPT to have only one continuous vessel. Thus, no add-on fem-pop codes were created.

Pre-service Time has been Substantially Reduced From Survey Data
Patients requiring vascular intervention are typically older and have multiple medical co-morbidities. In order to have a fem-pop lesion sufficiently severe to require treatment the vignette patient probably has 50-100 pack-year of smoking, and she almost certainly has an element of coronary disease and COPD. These patients move slowly and require lots of TLC in order to obtain appropriate informed consent and accomplish all other pre-service tasks as well as conscious sedation. The survey respondents median pre-service evaluation time was 70 minutes with 15 minutes of scrub, dress and wait, for a total of 85 minutes. Our consensus panel voted to reduce the survey pre-time by 44% to 40 minutes of pre-service evaluation, 3 minutes of positioning, and 5 minutes of scrub, dress, wait. We recommend starting with pre-service package 2B. We believe it is fully justified to add 7 minutes to pre-service evaluation to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging necessary for the procedure, and to coordinate all technical personnel. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views to treat the lesion in question. These shorter pre-service times have been used in all the following comparisons with reference services.

How is Femoral/Popliteal Angioplasty Currently Reported and Valued?
Component coding is used currently to report this procedure. The primary procedure is assigned full RVU value while subsequent 0-, 10-, and 90-day global procedures receive a 50% multiple procedure payment reduction. XXX radiological supervision and interpretation codes are not subject to a multiple procedure payment reduction. The procedure that will soon be reported with 37224 is currently reported with the existing fem-pop angioplasty code (35474 @ 7.35 RVUs) plus the existing radiological S&I code for balloon angioplasty (75962 @ 0.54 RVUs) plus one catheterization code that would be used for this procedure, typically 36247 (6.29 RVUs).

Therefore, the typical current work RVUs for iliac angioplasty may be calculated as:

Fem-pop angioplasty		7.35
+ Radiologic S&I		0.54
+ Catheterization		3.15 (after multiple procedure reduction)
Total	=	11.04 RVUs for typical case

Thus, our current median survey recommendation of 9.00 work RVUs for new code Z9 would represent an 18.5% reduction compared to this component code reporting approach with current 2010 values.

Comparison with Key Reference Service CPT 61640 – RVW 12.32

Key reference 61640 was chosen by 14 survey respondents. This service, "Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel" has an RVW of 12.32, intra service time of 90, 10 minutes more than the median 80 minutes by survey respondents. This reference service is clinically analogous in that it describes catheterization of third rder small-diameter vessels, fluoroscopy and road-mapping of vessels that are at a significant distance from the access ite. Multiple catheter and guidewire exchanges are required adding to the length and complexity of these procedures. Angioplasty in both settings requires prolonged inflation times, removal of angioplasty balloons, re-evaluation of the treated lesion, and repeat angioplasty. The time duration of angioplasty for vasospasm is likely greater, but the treatment length of the femoropopliteal vessel is 5-10 times longer. While it can be argued that working in the intracranial bed is more intense, those vessels are typically free of atherosclerotic plaque of the thickness and irregularity of that encountered in the peripheral vascular disease patient, and the likelihood for distal embolization is greater in the peripheral vascular patient. Thus, while our Consensus Panel will not argue equivalence of intensity between 37224 and 61640, the discrepancy is not a dramatic as one might originally think.

An estimate for the RVW of 37224 can be established by considering this reference. Pre-service work of 61640 is 1.44 compared to 1.00 for 37224. Post-service work of 61640 is 1.34 compared to 0.67 for 37224. Intra-service work is less by time (80/90 x 9.54 = 8.48) and less by intensity (0.092/0.106 x 8.48 = 7.36). Thus, an RVW for the new service can be estimated as:

Pre-service	1.00
Intra-service	7.36
Post-service	0.67
Total Service	9.03

Thus, making appropriate adjustments for pre, intra, and post-service time and intensity compared to the key reference service, the recommended median survey RVU of 9.00 is very well justified by this comparison.

Comparison with MPC List Code 1, CPT 43269 – RVW 8.20

43269 "Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body nd/or change of tube or stent" is a 0-day MPC service with 40 minutes pre-time, 71 minutes intra-time, and 30 minutes post-time. Both the new service and 46269 are high-tech therapeutic procedures that require complex imaging and maneuvering inside a body conduit. RVW for 43269 is 8.20, and the major adjustment to estimate an RVW for 37224 from this reference service lies in the pre-service work and intra-service work. Adjustment for pre-service is 1.00 - 0.83 = 0.17 in favor of the new code. Intra-service work of 43269 is 6.70, and to adjust for time that value needs to be multiplied by 80/70 = 1.14 x 6.70 = 7.66. Complexity is roughly the same. Thus, 37224 can be estimated by adding the increase in intra-service work (7.66-6.70 = 0.96) to the RVW of 43269.

Thus, the estimated RVW of 37224 should be 8.20 (MPC RVW) + 0.17 (pre-service adjustment) + 0.96 (intra-service adjustment) = 9.33. In conclusion, comparison with this MPC code with very similar time and intensity inputs justifies an RVW of 9.33, which is just a bit higher than our recommended median survey value of 9.00

Comparison with MPC List Code 2, CPT 58561 – RVW 9.99

A closely valued MPC list service is 58561 "Hysteroscopy, surgical; with removal of leiomyomata" with a work RVU of 9.99 compared to the 9.00 RVUs we recommend for 37224. The RUC valued 58561 based on a survey demonstrating 40 minutes of pre-service time, which is slightly less than 37224 at 48 minutes. 58561 has 75 minutes of intra-service time, 5 min less than new code 37224 (80 min intra). Finally, both codes have 30 minutes of post-service time. Hysteroscopy involves entering and distending the endometrial cavity with subsequent removal of leiomyomata. Femoral angioplasty involves entering a major artery in the body with subsequent dilation exactly at the site of a hemodynamically significant stenosis. Both services are certainly intense and complex, probably of equal magnitude, and 37224 fem-pop angioplasty involves 5 additional minutes of intra-service time. In summary, 58561 has an RVW of 9.99 and an intra-service time of 75 min. Even without adding work RVUs for the additional 5 min of intra-service time, this MPC service comparison readily justifies the recommended median survey RVW of 9.00 for 37224.

Comparison with Other Angioplasty Codes in this Proposal

The recommended RVW for fem-pop angioplasty (37224) is 9.00. This is more than the 8.15 RVW we recommend for iliac angioplasty (372XX). The increment of 0.85 RVUs is justified primarily by the additional intra-service time, 80 minutes for 37224 vs. 60 min. for 372XX. The fem-pop approach is typically performed from the opposite groin by puncturing the common femoral artery, directing the catheter centrally towards the aorta, then selectively catheterizing the common iliac, the external iliac, the superficial femoral artery and finally the popliteal artery. This requires substantially more time than catheterization for the iliac artery angioplasty.

The recommended RVW for this fem-pop angioplasty procedure (9.00) is appropriately lower than that which recommend for tibial artery angioplasty (372X8, RVW 12.00).

Services Reported with multiple CPT codes

The typical percutaneous fem-pop angioplasty will be reported with only one code, and that is why we checked "no" to the question below about services reported with multiple CPT codes. However, if the patient has not undergone a recent diagnostic angiographic exam, and if all other criteria for a diagnostic study were met, the appropriate diagnostic arteriography code could be added (eg 75710). Likewise, providers who require ultrasound guidance to gain arterial access could also report CPT 76937 (RVW 0.30) as long as the meet the documentation requirements of that code.

IWPUT

IWPUT of 37224 fem-pop balloon angioplasty is 0.092 with inputs as noted above. This is typical for high intensity percutaneous services that do not include lower intensity opening and closing time as in some surgical operations. This IWPUT also lies well within the range of the current proposal and existing IWPUTS for vascular intervention. For example:

Service	RUC Year	IWPUT
36821 open wrist AV fistula	2008	0.083 (appropriately lower than 37224)
37224 fem-pop angioplasty	**New**	**0.092**
92980 Coronary stent	1994	0.105 (appropriately higher IWPUT than 374X4)
37182 TIPS	2002	0.105 (appropriately higher IWPUT than 374X4)
61640 Intracranial angioplasty	2005	0.106 (appropriately higher IWPUT than 374X4)
37215 Carotid stent	2004	0.122 (appropriately higher IWPUT than 374X4)

Summary: We present an 89 person RUC survey with tightly clustered responses around the median RVW of 9.00. This RVW is supported by comparison to the key reference service (36478) and two MPC services (31600 & 58561). The recommended RVW for this fem-pop angioplasty is appropriately more than the proposed iliac angioplasty RVW, and appropriately less than the tibial artery angioplasty RVW. IWPUT falls within the range of arterial intervention. Our recommendation is substantially lower than the estimate of current payment for this service. We believe the median survey value of 9.00 is the most accurate relative value recommendation for 37224.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 35474 75962 36247

How often do physicians 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 surgery How often? Commonly

Specialty radiology How often? Commonly

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. Unable to estimate National frequency.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 33,803 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached table with estimated Medicare frequency.

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 93528

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:37225 Tracking Number Z10 Specialty Society Recommended RVU: **12.00**

Global Period: 000 RUC Recommended RVU: **12.00**

CPT Descriptor: Revascularization, femoral/popliteal artery(s), unilateral; with atherectomy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52-year-old female with diabetes and a history of coronary artery disease is seen for rest pain in the right foot. Diagnostic angiography reveals long segment diffuse disease of the mid to distal superficial femoral artery extending into the popliteal artery. It is treated with atherectomy.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 93%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 61%

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

Description of Pre-Service Work: Based on patient symptoms, signs, physical findings and pre-procedural studies, estimate the range of guiding catheters, selective catheters, sheaths, guidewires, balloons, and atherectomy devices that may be required, and ensure availability. Assess need for stand-by devices that might be needed emergently (eg, stents and covered stents). Review results of preadmission testing, with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Reexamine patient to make sure that physical findings have not changed and update H&P. Discuss procedure detail plan, including alternatives and risks with patient and family. Obtain informed consent for procedure and conscious sedation. Mark access sites. Check interventional suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Ensure all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with all required devices. Ensure the patient is appropriately positioned on the table and intravenous access has been achieved. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Supervise sterile prep of access site(s) and subsequent draping. Perform pre-procedural "time-out."

Description of Intra-Service Work: Conscious sedation is administered and adequate conscious sedation monitoring is verified. A suitable access vessel is cannulated either percutaneously or with open exposure of the vessel, and a sheath is placed into the access artery. A catheter and guidewire are manipulated into the diseased femoral artery using fluoroscopic

guidance, and the sheath is advanced into the ipsilateral common femoral artery. Roadmapping images are obtained for vessel sizing and to document anatomy. The area of stenosis/occlusion is crossed with a guidewire. It may be appropriate to place a distal embolic protection device, which may require pre-dilatation of a tight stenosis or area of occlusion. An atherectomy may be performed primarily or secondarily. Based on vessel measurements, an appropriate atherectomy device is chosen and is advanced into the diseased segment and positioned using fluoroscopic guidance and contrast injection. Multiple passes are made with the atherectomy device, physically removing plaque from the vessel. The atherectomy catheter may require periodic removal from the vessel to empty the collection chamber for plaque. It is then introduced into the vessel again over the wire and the process is repeated until the desired amount of plaque has been removed. Because of the length and extent of disease, it may require use of more than one atherectomy device to open the entire segment of disease. Atherectomy may be done in conjunction with balloon angioplasty, either in the same segment of the vessel or in separate segments of the vessel, depending on anatomy and pathology present. Imaging is performed after the atherectomy. If the lesion has been satisfactorily opened, angioplasty would not be performed at that level. If the lesion is incompletely opened, it could be treated further with additional atherectomy and/or with balloon angioplasty. An appropriately sized angioplasty balloon catheter is advanced to the area of stenosis and is positioned using fluoroscopic guidance, and then is inflated to the appropriate pressure and time for opening of the lesion. The balloon is removed or pulled back over the wire, and follow-up images are obtained with contrast injection to determine if the stenosis has been adequately treated. Multiple balloon inflations may be required, or additional balloons with larger or smaller diameters may be used. If there are multiple segments of disease within any femoral and/or popliteal segment(s) in the same leg, these are also treated with appropriate-sized balloon(s). Once a satisfactory result has been documented, imaging is repeated into the foot to document no distal complication and that there is run-off into the foot as desired. Medications such as nitroglycerine may be given if spasm is seen distally. The embolic protection device is retrieved if used, the sheath is removed, and hemostasis obtained with manual compression, closure device, or surgical closure of the arteriotomy.

Description of Post-Service Work: Apply sterile dressings. As needed, assist team in moving patient to stretcher. Discuss post-procedure care with recovery area staff. Write post-procedure orders for care and pain medication. Write brief procedure note. Record contrast volume and radiation exposure time. Review all films and dictate interpretation. Repeat patient exam and assessment of vital signs and perfusion of treated limb multiple times in recovery area, as needed. Monitor groin puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). Write orders for follow-up labs, x-rays. All appropriate medical records are completed, with copy to referring physician.

Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, x-rays, and patient care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Joseph Babb, MD; David Han, MD; Clifford Kavinsky, MD; Arthur Lee, MD; Geraldine McGinty, MD; Gerald Niedzwiecki, MD; Gary Seabrook, MD; Mathew Sideman, MD; Zeke Silva, MD; Gregory Thomas, MD; Sean Tutton, MD; Robert Vogelzang, MD; Robert Zwolak, MD				
Specialty(s):	cardiology (ACC, SCAI); vascular surgery (SVS); radiology (ACR, SIR)				
CPT Code:	37225				
Sample Size:	600	**Resp N:**	82	**Response:** 13.6 %	
Sample Type:	Random	**Additional Sample Information:** random and panel			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**5.00**	10.00	225.00
Survey RVW:	6.25	9.13	**12.00**	14.82	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	90.00	**118.00**	130.00	270.00

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: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	37225	**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**	**33.00**	**7.00**
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:		**118.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 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
37184	000	8.66	**RUC Time**

CPT Descriptor Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
36830	090	12.03	**RUC Time**	27,767

CPT Descriptor 1 Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)

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:** 29.2 **%**

TIME ESTIMATES (Median)	CPT Code: 37225	Key Reference CPT Code: 37184	Source of Time RUC Time
Median Pre-Service Time	48.00	40.00	
Median Intra-Service Time	118.00	90.00	
Median Immediate Post-service Time	30.00	30.00	
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	**196.00**	**160.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.75	3.42
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.92	3.67
Urgency of medical decision making	3.67	3.42
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.45	3.91
Physical effort required	4.18	3.82
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.17	3.58
Outcome depends on the skill and judgment of physician	4.25	3.75
Estimated risk of malpractice suit with poor outcome	3.58	3.50

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.45	3.36
Intra-Service intensity/complexity	4.45	3.64
Post-Service intensity/complexity	3.27	3.09

Additional Rationale and Comments

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

Why is this Code Being Presented to the RUC?
The family of percutaneous interventional codes was identified by the RUC 5-Year Review Identification Workgroup for higher than anticipated increase in volume.

What is the "big picture" overview of this multiple code procedure?
The family includes four possible treatment modalities (angioplasty, stenting, atherectomy, stenting plus atherectomy) that can be used in three arterial beds (iliac, femoropopliteal, tibial). This SoR represents atherectomy in the femoral/popliteal arterial bed.

The New Codes Bundle selective catheterization, intervention and radiological S&I
Currently, all percutaneous vascular intervention procedures are reported with the component coding approach, meaning that at least, three codes are used to report each treatment at any single level in the arterial tree. The basic three codes currently include 1) a selective catheterization code, plus 2) a treatment code, plus 3) a radiological supervision and interpretation code. In addition, many providers also report simultaneous balloon angioplasty on the same arterial segment during the same session. Thus, current reporting for this service oftentimes additionally includes a balloon angioplasty code (eg 35474) and the S&I for the angioplasty (eg 75962).

In contrast, this new code in this family BUNDLES all of these steps in a single code. New code 37225 will replace the use of 36247 (selective catheterization) plus 35493 (atherectomy) plus 75992 (atherectomy S&I) plus 35474 (angioplasty when reported) plus 75962 (angioplasty S&I when reported). In summary, this new code will BUNDLE as many as five separate codes now used to report fem-pop atherectomy.

Are there Add-On Codes in the femoral/popliteal region?
No. Although the iliac arterial bed has three distinct vessels (common iliac artery, external iliac artery, internal iliac artery), and the tibial arterial bed has four vessels (tibial-peroneal trunk, anterior tibial, posterior tibial, peroneal), the CPT Panel considered the femoral/popliteal region as one long continuous vessel. Thus, no add-on codes were created for the fem-pop region.

How is a Fem-Pop Atherectomy Currently Reported and Valued?
Component coding with multiple procedure payment reduction is used currently to report this procedure. The primary procedure is assigned full RVU value while subsequent 0-, 10-, and 90-day global procedures receive a 50% multiple procedure payment reduction. However, the XXX radiological supervision and interpretation codes are not subject to a multiple procedure payment reduction. The procedure that will soon be reported with 37225 is currently reported, at the very least, with the existing atherectomy code (35493 @ 8.09 RVW) plus the existing radiological S&I code for atherectomy (75992 @ 0.54 RVW) plus one catheterization code, typically 36247 (6.29 RVW). In addition many providers additionally report a balloon angioplasty and balloon angioplasty S&I during an atherectomy procedure (35474 @ 7.35 RVUs cut by 50% for multiple procedure = 3.68, plus 0.54 for the angioplasty S&I).

Thus, a current potential work RVU approach could be estimated as:

Fem/pop atherect	8.09	
Atherectomy S&I	0.54	
Fem/pop angioplasty	3.68	(after multiple procedure payment reduction)
Angioplasty S&I	0.54	
Catheterization	3.15	(after multiple procedure payment reduction)
Total =	16.00 RVUs may be reported for a fem/pop atherectomy when PTA is simultaneously reported.	

Thus, our current median survey recommendation of 12.00 work RVUs for new code Z10 would represent a 26% reduction compared to this component code approach using current 2010 RVUs.

re-service Time has been Substantially Reduced From Survey Data
Patients requiring vascular intervention are typically older and have multiple medical co-morbidities. In order to have an iliac lesion sufficiently severe to require treatment, the vignette patient probably has 50-100 pack-year of smoking, and she has coronary disease and diabetes. These patients move slowly and require lots of TLC in order to obtain appropriate informed consent and accomplish all other pre-service tasks as well as conscious sedation. The survey

respondents median pre-service evaluation time was 70 minutes with 15 minutes of scrub, dress and wait, for a total of 85 minutes. Our consensus panel voted to reduce the survey pre-time by 43% to 40 minutes of pre-service evaluation time, 3 minutes of positioning time, and 5 minutes of scrub/dress/wait time. We recommend starting with pre-service package 2B. We believe it is fully justified to add 7 minutes to pre-service evaluation to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging necessary for the procedure, and to coordinate all technical personnel. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views to treat the lesion in question. It is important to note that all subsequent comparisons with key and MPC reference services are presented using these reduced pre-times.

Comparison with Key Reference Service 37184 – RVW 8.66
This is an unusual situation in which the key reference code 37184 "Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel" is a similar clinical activity, but the reference has a much shorter intra-service time and therefore a much lower RVW than the new service we are presenting. We believe the survey respondents chose this service for its clinical similarity, in that the mechanical thrombectomy work is similar to an atherectomy. This is the only RUC-valued 0-day global code that has any clinical similarity to 37225.

37184 was chosen by 24 survey respondents. It was valued by the RUC at 8.66 in 2005. Pre-service time and work of 37225 and 37184 are essentially equivalent. The new code 37225 has 118 minutes of intra-service time compared to 90 minutes for the reference. Post-service time is identical.

Intra-service work of 37184 is 7.24 RVUs, and this must be increased by 118/90 = 1.31 to account for the intra-service time difference. Thus, 7.24 x 1.31 = 9.48 RVUs (an increase of 2.24) represents an appropriate estimate for intra-service work of the new code. All other things being equal, the relative value of the new code compared to the reference may be calculated as the current value of 37184 (8.66) plus the increment reflecting additional intra-service time (2.24), resulting in a total RVW of 10.90. Thus, adjusting Key Reference 37184 upward to account for more intra-time at equal clinical intensity we derive an RVW of 10.90, closely justifying the recommended median RVW of the new code at 12.00.

Comparison with MPC List CPT 36830 – RVW 12.03
The most closely valued MPC list service to our recommended RVW of 12.00 is CPT 36830 "Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)" that happens to be a vascular surgery service, albeit open surgery rather than percutaneous. 36830 has a pre-time of 55 minutes, very close to that of 37225 at 48 minutes. 36830 has essentially the same intra-service time at 120 minutes compared to the new service 118 minutes. Finally, both codes have nearly the same post-service time 30 min for the new code compared to 25 min for 36830. Thus, about the only difference is that 36830 is a 90-day global with one 99212 visit, valued at 0.45 RVUs. Both services are certainly intense and complex, although opening and closing 36830 may be less complex than the other portions of this service, and perhaps less complex than the entirety of 37225. We can build an RVW for 37225 from 36830 by cleaving away the post-op visit, so 12.03 – 0.45 = 11.58. There is very little additional adjustment to make. Thus, reducing the RVW of the 90-day global service to eliminate the post-discharge visits results in an RVW of 11.58, again very close to the 12.00 median survey RVW recommendation for the new service.

IWPUT
IWPUT of 37225 at the median survey recommended RVW is 0.088. This is a little less than IWPUTs for stenting and angioplasty, probably related to the deliberately slow back and forth catheter movements required during the atherectomy.

Summary: We present an 82 person RUC survey with tightly clustered responses around the median RVW of 12.00. This RVW is supported by comparison to the key reference service (37184) and a vascular surgery MPC service (36830). The recommended RVW for this fem-pop atherectomy is appropriately a bit more than the proposed fem-pop stent RVW, primarily based on additional intra-service time. IWPUT falls within the range of arterial intervention. Our recommendation is substantially lower than the estimate of current payment for this service. We believe the median survey value of 12.00 is the most accurate relative value recommendation for 37225.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 35493 75992 36247 35474 75962

How often do 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 cardiology	How often? Commonly
Specialty surgery	How often? Commonly
Specialty radiology	How often? Commonly

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. Unable to estimate National frequency.

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 23,447 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached table with estimated Medicare frequency.

Specialty	Frequency	Percentage	%
`pecialty	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? (ie. simil work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 34833

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:37226 Tracking Number Z11 Specialty Society Recommended RVU: **10.49**

Global Period: 000 RUC Recommended RVU: **10.49**

CPT Descriptor: Revascularization, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old male with a long history of smoking, coronary artery disease, hypertension, and hypercholesterolemia is evaluated for short-distance claudication of the right leg. Diagnostic studies demonstrate a 10-cm segment of occlusion of the distal superficial femoral artery and focal stenosis of the distal popliteal artery. It is treated with stent placement.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 92%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 61%

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

Description of Pre-Service Work: Based on patient symptoms, signs, physical findings and pre-procedural studies, estimate the range of guiding catheters, selective catheters, sheaths, guidewires, balloons, and stents that may be required, and ensure availability. Assess need for stand-by devices that might be needed emergently (eg, covered stents). Review results of preadmission testing, with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Reexamine patient to make sure that physical findings have not changed and update H&P. Discuss procedure detail plan, including alternatives and risks with patient and family. Obtain informed consent for procedure and conscious sedation. Mark access sites. Check interventional suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Ensure all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with all required devices. Ensure the patient is appropriately positioned on the table and intravenous access has been achieved. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Supervise sterile prep of access site(s) and subsequent draping. Perform pre-procedural "time-out."

Description of Intra-Service Work: Conscious sedation is administered and adequate conscious sedation monitoring is verified. A suitable access vessel is cannulated either percutaneously or with open exposure of the vessel, a sheath is placed at the arteriotomy, and a catheter and guidewire are manipulated into the diseased femoral artery using fluoroscopic

guidance. Roadmapping images are obtained for vessel sizing and to document anatomy. The area of stenosis/occlusion is crossed with a guidewire. If an occlusion is present, and if it is impossible to manipulate the wire through the occlusion, the wire is exchanged out for a re-entry device. The re-entry device is used to negotiate through the occlusion and back into the flow channel of the reconstituted artery beyond the occlusion. Once crossed, re-entry catheter is exchanged out for a wire, and if an embolic protection device is to be used, it is inserted at this point. The target lesion may be initially treate with balloon angioplasty, either as an intended primary therapy, or as pre-dilatation to allow passage of the stent deliver, system (in either case, the balloon angioplasty is included, i.e. bundled, with the work of the stent placement). If the stent is intended as the primary therapy, an appropriately sized stent is selected and introduced to the lesion through the sheath. Using fluoroscopic guidance and appropriate roadmapping, the stent is positioned across the intended treatment zone, and is deployed, either by placement of a self-expanding stent or balloon-expandable stent. The stent may be seated or fully opened with additional ballooning. The stent delivery system and balloon are removed or pulled back over the wire, and follow-up images are obtained with contrast injection to determine if the stenosis has been adequately treated. Multiple balloon inflations may be required, or additional balloons with larger or smaller diameters may be used. If it was intended that the primary therapy for the lesion was to be balloon angioplasty, but that fails to open the lesion or results in dissection or other complication, a stent is then introduced into the vessel and is deployed to achieve patency of the lesion. If there are multiple segments of disease within the ipsilateral femoral and/or popliteal artery segments, these are also treated with appropriate-sized stent(s) and/or balloons. Once a satisfactory result has been documented and imaging confirms flow to the foot without distal complication, the embolic protection device (if used) is removed, the sheath is removed and hemostasis obtained with manual compression, closure device, or surgical closure of the arteriotomy.

Description of Post-Service Work: Apply sterile dressings. As needed, assist team in moving patient to stretcher. Discuss post-procedure care with recovery area staff. Write post-procedure orders for care and pain medication. Write brief procedure note. Record contrast volume and radiation exposure time. Review all films and dictate interpretation. Repeat patient exam and assessment of vital signs and perfusion of treated limb multiple times in recovery area, as needed. Monitor groin puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). Write orders for follow-up labs, x-rays. All appropriate medical records are completed, with copy to referring physician.

Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharg criteria are met, with appropriate orders for follow-up labs, x-rays, and patient care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Joseph Babb, MD; David Han, MD; Clifford Kavinsky, MD; Arthur Lee, MD; Geraldine McGinty, MD; Gerald Niedzwiecki, MD; Gary Seabrook, MD; Mathew Sideman, MD; Zeke Silva, MD; Gregory Thomas, MD; Sean Tutton, MD; Robert Vogelzang, MD; Robert Zwolak, MD				
Specialty(s):	cardiology (ACC, SCAI); vascular surgery (SVS); radiology (ACR, SIR)				
CPT Code:	37226				
Sample Size:	600	**Resp N:**	89	**Response:** 14.8 %	
Sample Type:	Random	**Additional Sample Information:**	random and panel		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	8.00	**15.00**	30.00	300.00
Survey RVW:	5.65	8.66	**10.49**	15.00	22.00
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	75.00	**90.00**	120.00	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):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
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**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 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:	37226	**Recommended Physician Work RVU: 10.49**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**33.00**	**7.00**
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:		**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**
ther 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
92980	000	14.82	**RUC Time**

CPT Descriptor Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
58561	000	9.99	**RUC Time**	1,075

CPT Descriptor 1 Hysteroscopy, surgical; with removal of leiomyomata

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
37215	090	19.68	**RUC Time**

CPT Descriptor Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 21.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 37226**	**Key Reference CPT Code:** 92980	**Source of Time**
Median Pre-Service Time	48.00	45.00	**RUC Time**
Median Intra-Service Time	90.00	120.00	
Median Immediate Post-service Time	30.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0 00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Total Time	**168.00**	**225.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.70	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.70	3.50
Urgency of medical decision making	3.80	3.40
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.30	3.80
Physical effort required	3.80	3.44
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.80	3.50
Outcome depends on the skill and judgment of physician	4.30	4.00
Estimated risk of malpractice suit with poor outcome	4.00	3.70

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.90	2.90
Intra-Service intensity/complexity	4.40	4.10
Post-Service intensity/complexity	3.00	2.80

Additional Rationale and Comments

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

Why is this Code Being Presented to the RUC?
The family of percutaneous interventional codes was identified by the RUC 5-Year Review Identification Workgroup for higher than anticipated volume growth.

What is the "big picture" overview of this multiple code procedure?
The family includes four possible treatment modalities (angioplasty, stenting, atherectomy, stenting plus atherectomy) that can be used in three arterial beds (iliac, femoropopliteal, tibial). This SoR represents stent placement in the femoral/popliteal arterial bed.

The New Codes Bundle Selective Catheterization plus Intervention plus Radiologic Supervision and Interpretation
Currently, all percutaneous vascular intervention procedures are reported with the component coding approach, meaning that at least, three codes are used to report each treatment at any single level in the arterial tree. The minimum three codes currently used to report this service include 1) a selective catheterization code, plus 2) a stent code, plus 3) a radiological supervision and interpretation code. However, many providers also simultaneously report balloon angioplasty and an angioplasty S&I on the same arterial segment during the stent procedure.

In contrast, this new code BUNDLES all three of these steps, and all associated angioplasty into a single code. Thus, new code 37226 will REPLACE the use of 36247 (typical selective catheterization code) plus 37205 (non-coronary stent) plus 75960 (peripheral stent S&I), and for providers who also report balloon angioplasty, the new code will REPLACE 35473 (angioplasty) plus 75962 (angioplasty S&I) when performed during the same session on the fem-pop vessel. In summary, the new codes will BUNDLE as many as five separate codes now used to report fem-pop stent.

How is a Fem-Pop Stent Currently Reported and Valued?
Component coding with multiple procedure payment reduction is used currently to report this procedure. The primary procedure is assigned full RVW value while subsequent 0-, 10-, and 90-day global procedures receive a 50% multiple procedure payment reduction. However, XXX radiological S&I codes are not subject to a multiple procedure payment reduction. The procedure that will soon be reported with 37226 is currently reported with the existing stent code (37205 @ 8.27 RVW) plus the existing radiological S&I code for peripheral stent (75960 @ 0.82 RVW) plus one catheterization code, typically 36247 (6.29 RVW). In addition, many providers also report a balloon angioplasty (35474, 7.35 RVW) and balloon angioplasty S&I (75962, 0.54 RVW) during a fem/pop stent procedure. A typical high-end relative value could be estimated as:

Fem/pop stent	8.27	
Stent S&I	0.82	
Fem/pop angioplasty	3.68	(after multiple procedure payment reduction)
Angioplasty S&I	0.54	
Catheterization	3.15	(after multiple procedure payment reduction)
Total =	16.46 RVUs for placement of a fem/pop stent if an angioplasty is simultaneously reported.	

Thus, our current median survey recommendation of 10.49 work RVUs for new code Z11 represents a 36% reduction compared to this stent coding approach when reported with simultaneous angioplasty. For providers who do not report simultaneous angioplasty the current component coding schedule would result in an RVW of 12.24, still 20% more than the median survey recommendation for the new code.

Are there Add-On Codes in the femoral/popliteal region?
No. Although the iliac arterial bed has three distinct vessels (common iliac artery, external iliac artery, internal iliac artery), and the tibial arterial bed has four vessels (tibial-peroneal trunk, anterior tibial, posterior tibial, peroneal), making add-on codes necessary, the CPT Panel considered the femoral/popliteal region as one long continuous vessel. Thus, no add-on codes were created for the femoro-popliteal arterial bed.

Pre-service Time has been reduced substantially from Survey Data
Patients requiring vascular intervention are typically older and have multiple medical co-morbidities. In order to have fem-pop lesion sufficiently severe to require treatment, the vignette patient probably has 50-100 pack-year of smoking, and he has known coronary artery disease, hypertension and hyperlipidemia. These patients move slowly and require lots of TLC in order to obtain appropriate informed consent and accomplish all other pre-service tasks as well as conscious sedation. The survey respondents median pre-service evaluation time was 70 minutes with 15 minutes of

scrub, dress and wait, for a total of 85 minutes. Our consensus panel voted to reduce the survey pre-time by 43% to 40 minutes of pre-service evaluation time, 3 minutes of positioning time, and 5 minutes of scrub/dress/wait time. We recommend starting with pre-service package 2B. We believe it is fully justified to add 7 minutes to pre-service evaluation to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging necessary for the procedure, and to coordinate all technical personnel. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views to treat the lesion in question.

Why Should Fem-Pop Stent have a higher RVW than Iliac Stent?
We recommend an RVW of 10.49 for femoral-popliteal stent in this SoR compared to a recommended RVW of 10.00 for iliac artery stent (37221, tracking Z6). These two services have identical pre-service, intra-service and post-service times. The reason why the fem-pop stent needs a higher relative value has to do entirely with greater intra-service complexity and intensity. It is more difficult to catheterize a patient a fem-pop stent than an iliac stent. The fem-pop approach is typically performed from the opposite groin by puncturing the common femoral artery, directing the catheter centrally towards the aorta, then selectively catheterizing the common iliac, the external iliac, the superficial femoral artery and finally the popliteal artery. This is substantially more work than catheterization for the iliac artery stent placement. In addition, the typical patient with the fem-pop arterial disease has a more complex lesion (10 cm occlusion in the vignette) compared to the iliac stent patient who typically harbors a severe stenosis but not an occlusion. This oftentimes mandates use of a re-entry catheter and an embolic protection device.

It is not clear to us why the intra-service median survey times of these two services turned out to be equal, although not as many people took the fem-pop stent survey (n=89) as did the iliac stent survey (n=126). However, there is no doubt that the fem-pop stent procedure is more complex, and that difference in complexity readily justifies our recommendation of 10.49 RVW for 37226 fem-pop stent compared to 10.00 RVW for 37221 iliac stent.

Comparison with Key Reference Service 92980 – RVW 14.82
The key reference code 92980 "Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel" was chosen by 19 respondents. 92980 is a 0-day global code valued by the RUC at 14.82 work RVUs. 92980 has 45 minutes of pre-service time compared to 48 minutes for the new code, so that is essentially equivalent. 93980 has 120 minutes of intra-service time, exactly 30 minutes more than that of new code 37226, which has 90 minutes. Thus, a significant downward adjustment must be made for reduced intra-time if one is going to compare the two services. Finally, 92980 has 60 minutes of post-time compared to 30 minutes for the new code, so an adjustment must be made there as well. So the analysis can be as follows.

Intra-service work of 92980 is 12.61 RVUs, and this must be reduced by 25% to adjust for the intra-service time difference, or -3.15 RVUs, down to 9.46 RVUs for intra-service work. Post-service work of 92980 is 1.34 RVUs, and this must be reduced by 50% to represent the new code, so this difference is -0.62 RVUs. Thus, the total reduction based on time adjustment is -3.15 - 0.62 = -3.77 RVUs that must be subtracted from the value of 92980 to approximate the value of the new code, or 14.82 – 3.77 = 11.05.

Based purely on time adjustments, the calculated value for 37226 would be 11.05. Although the survey respondents rated the complexity and intensity indicators of the new code to be essentially equivalent to that of 92980, our Consensus Panel agreed that fem/pop stent is slightly less intense than coronary stent. It is important to note that the vignette patient has a 10 cm occlusion, which is more difficult to cross than a stenosis.

The calculated intensity as measured by IWPUT is 0.105 for 92980 coronary stent and 0.098 for 37226 fem/pop stent, approximately 7% less. Carving another 7% from the 9.46 intra-service RVUs, results in a further reduction of -0.66 RVUs. Thus, the value of the new code adjusting for time is 11.05 and adjusting for intra-service intensity reduces that value another 0.66 RVUs such that the value of 37226 can be estimated as 11.05 – 0.66 = 10.39. After downwardly adjusting the 14.82 RVW of Key Reference 92980 to account for less time and somewhat lower intensity, this comparison results in an RVW of 10.39, a value that closely approximates the recommended median RVW of 10.49 for the new fem-pop stent code.

Comparison with MPC CPT 58561 – RVW 9.99
A closely valued 0-Day global MPC service is 58561 "Hysteroscopy, surgical; with removal of leiomyomata" with a work RVU of 9.99 compared to the 10.49 RVUs we recommend for 37226. The RUC valued 58561 based on a survey demonstrating 75 minutes of intra-service time, 15 minutes less than new code 37226 (90 min intra). The codes have similar pre-service and identical 30 minute post-service time. Hysteroscopy involves entering and distending the endometrial cavity with subsequent removal of leiomyomata. Fem-pop stent involves entering a major artery in the body with subsequent deployment of a metallic stent exactly at the site of a hemodynamically significant stenosis. Both services are certainly intense and complex, but 372X has 15 minutes of additional intra-service time. Intra-service work of 58561 is 8.49 RVUs. Adjustment for the intra-service time difference is 90/75 x 8.49 = 10.19. The best intensity adjustment involves comparing the IWPUTs, 0.098 for the new service and 0.113 for 58561. This results in 0.098/0.113 x 10.19 = 8.84. By these adjustments intra-service work of 37226 is 8.84-8.49 = 0.35 more in the new code than the reference, and total RVW of 37226 may be estimated as 9.99 (RVW of reference) + 0.35 (increment) = 10.34. With an RVW of 9.99 for the MPC reference, an adjustment for time and intensity results in an estimated 10.34 RVW for the new code, almost exactly the 10.49 median survey RVW that we recommend for the new service.

Comparison with Clinically Relevant CPT 37182 Transvenous Intrahepatic Portosystemic Shunt (TIPS)
Another clinically relevant comparison is CPT 37182 TIPS, which was valued by the RUC in 2002. TIPS is a 0-day global service with RVW 16.97, comprised of 30 minutes pre-time (0.60 RVUs) plus 150 minutes intra-time (15.70 RVUs) and 30 minutes post-time (0.60 RVUs). The main adjustment to draw a valid comparison lies in intra-service work. 372X1 is 60 minutes (40%) shorter, and approximately 7% less intense (IWPUT 0.105 for TIPS, 0.098 for new service). Thus, the 40% time adjustment would reduce intra-service work to 9.42, and a 7% downward intensity adjustment would reduce 9.42 to 8.76, for a net reduction of 6.94 work RVUs during the intra-service period. Pre-service adjustment is 0.40 in favor of the new service, while post-service work is the same.

Therefore, starting with 16.97 RVW for 0-day global service TIPS we can estimate the value for 37226 by removing 6.94 intra-service work RVUs and adding 0.4 pre-service RVUs, for an estimated value of 10.43 RVUs for the new service. This clinically relevant comparison also serves to validate our recommendation of the median survey 10.49 RVUs for 37226.

IWPUT Intensity

IWPUT of 37226 at the median survey recommended RVW is 0.098. This IWPUT lies well within the range of the current proposal and existing IWPUTS for vascular intervention and all comparison services:

Service	RUC Year	IWPUT
36821 open wrist AV fistula	2008	0.083 (appropriately less than 37226
372X1 iliac stent	proposed	0.092 (appropriately slightly less than 37226)
37226 fem-pop stent	**New**	**0.098**
92980 MPC Coronary stent	1994	0.105 (appropriately higher than 37226)
37182 MPC TIPS	2002	0.105 (appropriately higher than 37226)
61640 Intracranial PTA	2005	0.106 (appropriately higher than 37226)
58561 MPC Hysterscopy	1997	0.113
37215 Carotid stent	2004	0.122 (appropriately higher than 37226)

Services Reported with multiple CPT codes

The typical fem-pop stent will be reported with one code, and that is why we checked "no" to the question below about services reported with multiple CPT codes. However, if the patient has not undergone a recent diagnostic angiographic exam, and if all criteria for a diagnostic study are met, the appropriate diagnostic arteriography may be performed and reported (eg 75710, RVW 1.14). Likewise, providers sometimes require ultrasound guidance to gain arterial access, and they could additionally report the ultrasound guidance code CPT 76937 (RVW 0.30) as long as documentation requirements are met.

Summary: In conclusion, we provide an 89 person RUC survey with tightly clustered responses around the median RVW of 10.49. This RVW is fully supported by detailed comparisons to RUC-surveyed key reference service coronary stent (92980) plus the MPC procedure hysteroscopy (56581), plus RUC-surveyed carotid stent (37215), as well as RUC-surveyed TIPS (37182). The service has an IWPUT well within the range of other vascular procedures. Our recommendation is substantially lower than the best estimates of current payment for this service. We believe the median survey value of 10.49 is the most accurate relative value recommendation for 37226.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37205 75960 36247 35474 75962

How often do physicians 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 surgery	How often? Commonly
Specialty radiology	How often? Commonly

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. Unable to estimate National frequency.

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
60,781 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached table with estimated Medicare frequency.

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 37210

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:37227 Tracking Number Z12 Specialty Society Recommended RVU: **14.50**

Global Period: 000 RUC Recommended RVU: **14.50**

CPT Descriptor: Revascularization, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old male with a long history of smoking, cardiovascular disease, and severe pulmonary disease is seen for non-healing ulcer of the right foot. Diagnostic testing reveals total occlusion of the right superficial femoral artery with reconstitution of the popliteal artery above the knee. There is also 3-cm segment of stenosis of the popliteal artery below the knee. Treatment of both these lesions involves some combination of stent and atherectomy procedure(s).

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 91%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 63%

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

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Description of Pre-Service Work: Based on patient symptoms, signs, physical findings and pre-procedural studies, estimate the range of guiding catheters, selective catheters, sheaths, guidewires, balloons, atherectomy devices, and stents that may be required, and ensure availability. Assess need for stand-by devices that might be needed emergently (eg, covered stents). Review results of preadmission testing, with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Reexamine patient to make sure that physical findings have not changed and update H&P. Discuss procedure detail plan, including alternatives and risks with patient and family. Obtain informed consent for procedure and conscious sedation. Mark access sites. Check interventional suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Ensure all technical personnel have been familiarized with the upcoming procedure and techniques ıd that they are fully familiar with all required devices. Ensure the patient is appropriately positioned on the table and ıntravenous access has been achieved. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Supervise sterile prep of access site(s) and subsequent draping. Perform pre-procedural "time-out."

Description of Intra-Service Work: Conscious sedation is administered and adequate conscious sedation monitoring is verified. A suitable access vessel is cannulated either percutaneously or with open exposure of the vessel, and a sheath is placed into the access artery. A catheter and guidewire are manipulated into the diseased superficial femoral artery using fluoroscopic guidance, and the sheath is advanced into the ipsilateral common femoral artery. Roadmapping images are obtained for vessel sizing and to document anatomy. The area of stenosis/occlusion is crossed with a guidewire. If this not possible due to an occlusion, the guidewire is switched out for a re-entry catheter. This device is used to negotiate th occlusion, regain entry into the distal arterial lumen, and it is then switched out for a small diameter wire. An atherectomy may be performed primarily or secondarily. Based on vessel measurements, appropriate atherectomy device(s) is(are) chosen and is(are) advanced into the diseased segment and positioned using fluoroscopic guidance and contrast injection. Multiple passes are made with the atherectomy device(s), physically removing plaque from the vessel. The atherectomy catheter may require periodic removal from the vessel to empty the collection chamber for plaque. It is then introduced into the vessel again over the wire and the process is repeated until the desired amount of plaque has been removed. It may be appropriate to place a distal embolic protection device, which may require pre-dilatation of a tight stenosis or area of occlusion. Atherectomy may be done in conjunction with balloon angioplasty and/or stenting, either in the same segment of the vessel or in separate segments of the vessel, depending on anatomy and pathology present. Imaging is performed after the atherectomy. If the lesion has been satisfactorily opened, angioplasty or stent placement would not be performed at that level. If the lesion is incompletely opened, it could be treated further with additional atherectomy or with stent and/or balloon angioplasty. An appropriately sized stent would be positioned across the lesion and deployed, and may be completely opened and embedded into the wall of the vessel with additional balloon angioplasty. There may be multiple levels of disease in the vessel or there may be involvement of the common femoral and/or profunda femoral and/or popliteal segments. Some may be appropriately treated with atherectomy but others may be better treated with stenting with or without balloon angioplasty. After the lesions are treated, follow-up images are obtained with contrast injection to determine if the stenosis has been adequately treated. Once a satisfactory result has been documented, images are obtained to the foot to document desire flow has been obtained and that there are no distal complications. The embolic protection device is retrieved if used, the sheath is removed, and hemostasis obtained with manual compression, closure device, or surgical closure of the arteriotomy.

Description of Post-Service Work: Apply sterile dressings. As needed, assist team in moving patient to stretcher. Discuss post-procedure care with recovery area staff. Write post-procedure orders for care and pain medication. Write bri procedure note. Record contrast volume and radiation exposure time. Review all films and dictate interpretation. Repea patient exam and assessment of vital signs and perfusion of treated limb multiple times in recovery area, as needed. Monitor groin puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). Write orders for follow-up labs, x-rays. All appropriate medical records are completed, with copy to referring physician.

Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, x-rays, and patient care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Joseph Babb, MD; David Han, MD; Clifford Kavinsky, MD; Arthur Lee, MD; Geraldine McGinty, MD; Gerald Niedzwiecki, MD; Gary Seabrook, MD; Mathew Sideman, MD; Zeke Silva, MD; Gregory Thomas, MD; Sean Tutton, MD; Robert Vogelzang, MD; Robert Zwolak, MD				
Specialty(s):	cardiology (ACC, SCAI); vascular surgery (SVS); radiology (ACR, SIR)				
CPT Code:	37227				
Sample Size:	600	**Resp N:**	83	**Response:** 13.8 %	
Sample Type:	Random	**Additional Sample Information:**	random and panel		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**4.00**	15.00	175.00
Survey RVW:	6.50	10.00	**14.50**	17.00	35.00
Pre-Service Evaluation Time:			**65.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	60.00	108.00	**125.00**	165.00	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):	**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:	37227	**Recommended Physician Work RVU: 14.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**33.00**	**7.00**
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:		**125.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
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
37182	000	16.97	**RUC Time**

CPT Descriptor Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
92980	000	14.82	**RUC Time**	326,038

CPT Descriptor 1 Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel

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: 26 **% of respondents:** 31.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 37227**	**Key Reference CPT Code: 37182**	**Source of Time RUC Time**
Median Pre-Service Time	48.00	30.00	
Median Intra-Service Time	125.00	150.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	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	**203.00**	**210.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.17	4.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.25	4.50
Urgency of medical decision making	4.33	4.42
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.58	4.75
Physical effort required	4.17	4.67
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.25	4.58
Outcome depends on the skill and judgment of physician	4.50	4.58
Estimated risk of malpractice suit with poor outcome	4.08	4.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.92	4.25
Intra-Service intensity/complexity	4.58	4.75
Post-Service intensity/complexity	3.92	4.25

Additional Rationale and Comments

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

Why is this Code Being Presented to the RUC?

The family of percutaneous interventional codes was identified by the RUC 5-Year Review Identification Workgroup for higher than anticipated increase in volume.

What is the "big picture" overview of this multiple code procedure?
The family includes four possible treatment modalities (angioplasty, stenting, atherectomy, stenting plus atherectomy) tha can be used in three arterial beds (iliac, femoropopliteal, tibial). This SoR represents stent plus atherectomy in the femoral/popliteal arterial bed.

The New Codes Bundle Selective Catheterization plus Intervention plus Radiologic Supervision and Interpretation
Currently, all percutaneous vascular intervention procedures are reported with the component coding approach. For stent plus atherectomy a minimum of five codes are currently used to report this service, including 1) a selective catheterization code, plus 2) an atherectomy code, plus 3) a stent code, plus 4) a radiological S&I code for atherectomy, and 5) an S&I code for the stent. However, many providers also simultaneously report balloon angioplasty and an angioplasty S&I on the same arterial segment during this procedure, so that would mean two more codes.

In contrast, this new code BUNDLES all 5-7 of these steps into a single code. Thus, new code 37227 will REPLACE the use of 36247 (typical selective catheterization code) plus 37205 (non-coronary stent) plus 35493 (atherectomy) plus 75960 (peripheral stent S&I), and 75992 (atherectomy S&I). For providers who also report balloon angioplasty, the new code will also REPLACE 35474 (angioplasty) plus 75962 (angioplasty S&I) when performed during the same session on the fem-pop vessel. In summary, the new codes will BUNDLE as many as 7 separate codes now used to report fem-pop stent plus atherectomy.

Are there Add-On Codes in the femoral/popliteal region?
No. Although the iliac arterial bed has three distinct vessels (common iliac artery, external iliac artery, internal iliac artery), and the tibial arterial bed has four vessels (tibial-peroneal trunk, anterior tibial, posterior tibial, peroneal), the CPT Panel considered the femoral/popliteal region as one long continuous vessel. Thus, no add-on codes were created for the fem-pop region.

How is a Fem-Pop Stent plus Atherectomy Currently Reported and Valued?
Component coding with multiple procedure payment reduction is used currently to report this procedure. The primary procedure is assigned full RVU value while subsequent 0-, 10-, and 90-day global procedures receive a 50% multiple procedure payment reduction. However, XXX radiological supervision and interpretation codes are not subject to a multiple procedure payment reduction. The procedure that will soon be reported with 37227 is currently reported with the existing stent code (37205 @ 8.27 RVW) plus the existing radiological S&I code for peripheral stent (75960 @ 0.82 RVW) plus one catheterization code, typically 36247 (6.29 RVW) plus one atherectomy code (35493 @ 8.09 RVW) plus one atherectomy S&I (75992 @ 0.54 RVW). In addition, many providers additionally report a balloon angioplasty and balloon angioplasty S&I during this procedure (35474 @ 7.35 RVUs cut by 50% for multiple procedure = 3.66 plus 0.54 for the angioplasty S&I)

Thus, a current typical work RVU scenario could be estimated as:

Fem/pop stent	8.27	
Stent S&I	0.82	
Fem/pop atherectomy	4.05	(after multiple procedure payment reduction)
Atherectomy S&I	0.54	
Fem/pop angioplasty	3.66	(after multiple procedure payment reduction)
Angioplasty S&I	0.54	
Catheterization	3.15	(after multiple procedure payment reduction)
Total =	21.03 RVUs for fem/pop stent + atherectomy if an angioplasty is simultaneously reported	

Thus, our current median survey recommendation of 14.50 work RVUs for new code Z12 will represent a 31% reduction compared to the above component code reporting approach of this procedure using current 2010 RVUs.

Pre-service Time has been Substantially Reduced From Survey Data

Patients requiring vascular intervention are typically older and have multiple medical co-morbidities. In order to have an iliac lesion sufficiently severe to require treatment, the vignette patient probably has 50-100 pack-year of smoking, and he has coronary disease and hypertension. These patients move slowly and require lots of TLC in order to obtain appropriate informed consent and accomplish all other pre-service tasks as well as conscious sedation. The survey respondents median pre-service evaluation time was 75 minutes with 15 minutes of scrub, dress and wait, for a total of 90 minutes. Our consensus panel voted to reduce the survey pre-time by 47% to 40 minutes of pre-service evaluation time, 3 minutes of positioning time, and 5 minutes of scrub/dress/wait time. We recommend starting with pre-service package 2B. We believe it is fully justified to add 7 minutes to pre-service evaluation to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging necessary for the procedure, and to coordinate all technical personnel. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views to treat the lesion in question. It is important to note that in all subsequent comparisons with key and MPC reference codes, these reduced pre-service minutes have been employed.

Comparison with Key Reference Service CPT 37182 Transvenous Intrahepatic Portosystemic Shunt (TIPS)

The key reference service, CPT 37182 TIPS, was chosen by 26 survey respondents. TIPS was valued by the RUC in 2002. It is a 0-day global service with RVW 16.97, comprised of 30 minutes pre-time (0.60 RVUs) plus 150 minutes intra-time (15.70 RVUs) and 30 minutes post-time (0.60 RVUs). The main adjustment to draw a valid comparison with 37227 lies in intra-service work. 37227 is 25 minutes shorter (16.7%) and slightly less intense than TIPS. Thus, the 16.7% time adjustment would reduce intra-service work by 2.62 RVUS to 13.08, and an estimated downward intensity adjustment would reduce another 1.00 RVU to 12.08, for a net reduction of 3.62 work RVUs during the intra-service period.

In summary, starting with 16.97 work RVUs for the 0-day global service 37182, we can estimate the value for 37227 by removing 3.62 intra-service work RVUs, for an estimated value of 13.35 RVUs for the new service. This closely approximates our recommendation of the median survey of 14.50 RVUs for 37227.

Comparison with MPC Service 92980 – RVW 14.82

The MPC code 92980 "Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel" is a clinically relevant reference. 92980 is a 0-day global code valued by the RUC at 14.82 work RVUs. 92980 has 45 minutes of pre-service time compared to 48 minutes for the new code, so that is essentially equivalent. 93980 has 120 minutes of intra-service time, 5 minutes less than that of new code 37227, which has 125 minutes. Thus, a slight upward adjustment must be made for increased intra-time if one is going to compare the two services. Finally, 92980 has 60 minutes of post-time compared to 30 minutes for the new code, so an adjustment must be made there as well. So the analysis can be as follows.

Intra-service work of 92980 is 12.61 RVUs, and this must be increased by 4% for the intra-service time difference, or +0.50 RVUs, up to 13.11 RVUs for intra-service work. Post-service work of 92980 is 1.34 RVUs, and this must be reduced by 50% to represent the new code, so this difference is 0.62 RVUs. Thus, the total adjustment based on time adjustment is +0.50 (intra) - 0.62 (post) = -0.12 RVUs that must be subtracted from the value of 92980 to approximate the value of the new code, or 14.82 – 0.12 = 14.70.

Based purely on time adjustments, the calculated value for 37227 would be 14.70. However, the survey respondents rated the complexity and intensity indicators of the new code to be slightly less than that of 92980, and our Consensus Panel agreed. Thus, the value of the new code adjusting for time alone would be 14.70, and after making a downward adjustment for intra-service intensity, this would reduce that value of 37227 than can be estimated from 92980 to a level very close to our median survey value of 14.50. Thus, adjusting Key Reference 92980 to account for slightly more intra-time and slightly less intensity could result in an RVW very close to the recommended median RVU of the new code, which is 14.50.

Comparison with Clinically Relevant Service CPT 37215 Carotid Stent – RVW 19.68

Our Consensus Panel felt that CPT 37215 Carotid Stent placement would have been a perfect service to enter on the Reference Service List, save for the fact that it is a 90-day global service. We felt that survey respondents would not be able to perform the associated mathematics to carve away the post-service visits in order to derive an accurate comparison to the 0-day global service we are evaluating. However, the Consensus Panel readily performed this math based on the RUC database, and 37215 becomes an excellent service on which to assess the value of the new code.

37215 was valued by the RUC in 2004. It has an RVW of 19.68, and of this total, 4.51 RVUs derive from post-procedural visits that would not be part of a 0-day global. Thus, the 0-day comparison value of 37215 would be 19.68 – 4.51 = 15.07. The pre-service time of 37215 is 75 minutes evaluation plus 15 minutes SDW, together representing 1.80 RVUs. The pre-service time of 37227 is 43 min evaluation plus 5 min SDW, representing 1.00 RVUs, thus we need to subtract 0.80 RVU from 15.07 to adjust for pre-time, or 15.07-0.80 = 14.23. Intra-service work of 37215 is 12.60 with an intra-time of 37215 is 103 compared to 125 for 37227. In this situation, the 20% increase in intra-time for the new code likely counterbalances about an equal 20% reduction in intra-service intensity, and we suggest that in this case only the pre-service and post-service adjustments need be made to equate the two services.

In summary, starting with 19.68 RVUs for the 90-day global service of 37215, we can estimate a relative value for 37227 by beginning with 37215 RVW of 19.68. Subtract 4.51 RVUs for post-op visits = 15.07. This reduces 37215 to a 0-day service. Subtract 0.80 RVUs for the shorter pre-service time of 37227, = 14.23. Intra-service work is a wash, with 20% longer time for 37227 at approximately 20% lower intensity. Immediate post-service times are equivalent, so no adjustment. This relationship results in a 14.23 RVW for 37227, a value essentially at the recommended median survey of 14.50

Building the Stent plus Atherectomy Code from the Stent Code
Another clinically appropriate method to value the stent plus atherectomy code is to consider the RVW of the stent code and add a factor for the additional time and intensity of the atherectomy. We recommended the median survey value of 10.49 RVUs for the fem-pop stent code. This service has an intra-time of 90 minutes. The stent plus atherectomy code has an intra-time of 125 minutes, implying that the atherectomy portion of this service requires 35 minutes. The IWPUT of the fem-pop atherectomy (372X5 / tracking Z10) is 0.088. Thus, the increment of additional work may be calculated as 35 minutes x 0.088 RVU/min = 3.08 RVUs. Using this straightforward approach, the RVW for 37227 may be estimated at 10.49+3.08 = 13.57, a value that supports our median survey recommendation of 14.50 RVUs for 37227.

IWPUT Intensity
IWPUT of 37227 at the median survey recommended RVW is 0.103. This IWPUT lies well within the range of the curre proposal and existing IWPUTS for vascular intervention and all comparison services:

Service	RUC Year	IWPUT
36821 open wrist AV fistula	2008	0.083 (appropriately less than 37227
372X1 iliac stent	proposed	0.092 (appropriately slightly less than 37227)
37227 fem-pop stent + ath	**New**	**0.103**
92980 MPC Coronary stent	1994	0.105 (appropriately higher than 37227)
37182 MPC TIPS	2002	0.105 (appropriately higher than 37227)
61640 Intracranial PTA	2005	0.106 (appropriately higher than 37227)
58561 MPC Hysterscopy	1997	0.113
37215 Carotid stent	2004	0.122 (appropriately higher than 37227)

Services Reported with multiple CPT codes
The typical fem-pop stent + atherectomy will be reported with one code, and that is why we checked "no" to the question below about services reported with multiple CPT codes. However, if the patient has not undergone a recent diagnostic angiographic exam, and if all criteria for a diagnostic study are met, the appropriate diagnostic arteriography may be performed and reported (eg 75710, RVW 1.14). Likewise, providers sometimes require ultrasound guidance to gain arterial access, and they could additionally report the ultrasound guidance code CPT 76937 (RVW 0.30) as long as documentation requirements are met.

Summary: In conclusion, we provide an 83 person RUC survey with tightly clustered responses around the median RVW of 14.50. This RVW is fully supported by detailed comparisons to RUC-surveyed key reference service TIPS (37182) plus the MPC procedure coronary stent (92980), plus RUC-surveyed carotid stent (37215). The recommende RVW fits appropriately within this family of codes, and the service has an IWPUT well within the range of other vascular procedures. Our recommendation is substantially lower than the best estimates of current payment for this service. We believe the median survey value of 14.50 is the most accurate relative value recommendation for 37227.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37205 75960 36247 35493 75992 35474 75962

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 cardiology How often? Commonly

Specialty surgery How often? Commonly

Specialty radiology How often? Commonly

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. Unable to estimate National frequency.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
16,086 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached table with estimated Medicare frequency.

[redacted]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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 92980

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:37228 Tracking Number Z13 Specialty Society Recommended RVU: **11.00**

Global Period: 000 RUC Recommended RVU: **11.00**

CPT Descriptor: Revascularization, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old diabetic female presents with rest pain of the right foot. Diagnostic studies reveal single vessel run-off with only the anterior tibial artery patent, but it has focal stenoses in the proximal and mid portions of the vessel. It is treated with angioplasty.

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

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
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? 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

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Description of Pre-Service Work: Based on patient symptoms, signs, physical findings and pre-procedural studies, the physician estimates the range of guiding catheters, selective catheters, sheaths, guidewires, and balloons that may be required, and ensure availability. The need for stand-by devices that might be needed emergently (eg, stents and covered stents) is assessed. Results of preadmission testing are reviewed, with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Patient is reexamined to make sure that physical findings have not changed and H&P is updated. Procedure detail plan, including alternatives and risks, is discussed with patient and family. Informed consent is obtained for procedure and conscious sedation. Physician marks access sites. He or she checks interventional suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Physician ensures all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with all required devices. Physician ensures the patient is appropriately positioned on the table and intravenous access has been achieved. Physician dons radiation protection gear and ensures that all who will be in the interventional suite do likewise. e or she upervises sterile prep of access site(s) and subsequent draping. A pre-procedural "time-out"is performed.

Description of Intra-Service Work: Conscious sedation is administered and adequate conscious sedation monitoring is verified. Physical exam and fluoroscopy are used to localize the vessel and level for access. The access vessel is cannulated either percutaneously or with open exposure of the vessel, and an initial sheath is placed at the arteriotomy. A

catheter and guidewire are manipulated proximal to the diseased tibial/peroneal artery using fluoroscopic guidance. Roadmapping images are obtained for vessel sizing and to document anatomy. Exchange of initial sheath and guidewire are performed with new guiding sheath, exchange length crossing wire, and crossing catheter positioned. The area(s) of stenosis/occlusion is crossed with a guidewire. It may be appropriate to place a distal embolic protection device, which may require pre-dilatation of a tight stenosis. An appropriately sized balloon angioplasty catheter is advanced to the area stenosis and is positioned using fluoroscopic guidance, and then is inflated to the appropriate pressure and time for openin of the lesion. The balloon is removed or pulled back over the wire, and follow-up images are obtained with contrast injection to determine if the stenosis has been adequately treated. Multiple balloon inflations are required, and additional balloons with larger or smaller diameters may be used. If there are multiple segments of disease in the tibial-peroneal artery in this leg, they are also treated with the appropriate size balloon or balloons. Once a satisfactory result has been documented in the absence of extravasation or embolization, the embolic protection device is retrieved if used, the sheath is removed, and hemostasis obtained with manual compression, closure device, or surgical closure of the arteriotomy.

Description of Post-Service Work: Sterile dressings are applied. As needed, physician assists team in moving patient to stretcher. Post-procedure care is discussed with recovery area staff. Physician writes post-procedure orders for care and pain medication. He or she writes brief procedure note, and records contrast volume and radiation exposure time. Physician reviews all films and dictates interpretation. The patient exam and assessment of vital signs and perfusion of treated limb multiple times in recovery area is repeated, as needed. Physician monitors groin puncture site for hematoma. He or she discusses findings and treatment with family and patient (when awake). Physician writes orders for follow-up labs, x-rays. All appropriate medical records are completed, with copy to referring physician.

Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, x-rays, and patient care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Joseph Babb, MD; David Han, MD; Clifford Kavinsky, MD; Arthur Lee, MD; Geraldine McGinty, MD; Gerald Niedzwiecki, MD; Gary Seabrook, MD; Mathew Sideman, MD; Zeke Silva, MD; Gregory Thomas, MD; Sean Tutton, MD; Robert Vogelzang, MD; Robert Zwolak, MD				
Specialty(s):	Cardiology; Vascular Surgery; Radiology				
CPT Code:	37228				
Sample Size:	600	**Resp N:**	74	**Response:** 12.3 %	
Sample Type:	Random	**Additional Sample Information:**	random and panel		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**8.00**	20.00	180.00
Survey RVW:	5.50	9.05	**12.00**	14.00	24.00
Pre-Service Evaluation Time:			**65.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	45.00	75.00	**90.00**	120.00	240.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
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:	37228	**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:		**40.00**	**33.00**	**7.00**
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:		**90.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 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
61640	000	12.32	**RUC Time**

CPT Descriptor Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
92980	000	14.82	**RUC Time**	326,038

CPT Descriptor 1 Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel

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
37215	090	19.68	**RUC Time**

CPT Descriptor Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 21.6 **%**

TIME ESTIMATES (Median)	CPT Code: 37228	Key Reference CPT Code: 61640	Source of Time RUC Time
Median Pre-Service Time	48.00	77.00	
Median Intra-Service Time	90.00	90.00	
Median Immediate Post-service Time	30.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Total Time	**168.00**	**227.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.45	3.18
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.36	3.24
Urgency of medical decision making	3.91	4.18
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	4.09
Physical effort required	3.82	3.64
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.72	4.09
Outcome depends on the skill and judgment of physician	4.09	4.09
Estimated risk of malpractice suit with poor outcome	3.64	4.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.27	3.55
Intra-Service intensity/complexity	3.91	4.00
Post-Service intensity/complexity	3.18	3.45

Additional Rationale and Comments

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

Why is this Code Being Presented to the RUC?
The family of percutaneous interventional codes was identified by the RUC 5-Year Review Identification Workgroup for higher than anticipated increase in volume.

What is the "big picture" overview of this multiple code procedure?
The family includes four possible treatment modalities (angioplasty, stenting, atherectomy, stenting plus atherectomy) that can be used in three arterial beds (iliac, femoropopliteal, tibial). This SoR represents angioplasty alone in the tibial arterial bed.

The New Codes Bundle selective catheterization, intervention and radiological S&I
Currently, all percutaneous vascular intervention procedures are reported with the component coding approach, meaning that at least three codes are used to report each treatment at any single level in the arterial tree. The basic three codes currently include 1) a selective catheterization code, plus 2) a treatment code, plus 3) a radiological supervision and interpretation code. In contrast, the new codes in this family BUNDLE all three of these steps into a single code. Thus, new code 37228 will REPLACE the use of, for example, 36247 (selective catheterization) plus 37205 (non-coronary stent) plus 75960 (peripheral stent S&I).

Pre-service Time has been substantially Reduced From Survey Data
Patients requiring vascular intervention are typically older and have multiple medical co-morbidities. In order to have tibial disease sufficiently severe to require treatment, the vignette patient probably has 50-100 pack-year of smoking, diabetes, and he almost certainly has an element of coronary disease and COPD. These patients move slowly with painful feet and require lots of TLC in order to obtain appropriate informed consent and accomplish all other pre-service tasks as well as conscious sedation. The survey respondents' median pre-service evaluation time was 65 minutes with 13 minutes of scrub, dress and wait, for a total of 78 minutes. Our consensus panel voted to reduce the survey pre-time by 36% to 40 minutes of pre-service evaluation time, 3 minutes of positioning time, and 5 minutes of scrub/dress/wait time. We recommend starting with pre-service package 2B. We believe it is fully justified to add 7 minutes to pre-service evaluation to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging necessary for the procedure, and to coordinate all technical personnel. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views to treat the lesion in question.

How is a tibial angioplasty Currently Reported and Valued?
Component coding is used currently to report this procedure. The primary procedure is assigned full RVU value while subsequent 0-, 10-, and 90-day global procedures receive a 50% multiple procedure payment reduction. XXX radiological supervision and interpretation codes are not subject to a multiple procedure payment reduction. The procedure that will soon be reported with 37228 is currently reported with the existing tibial peroneal angioplasty code (35470 @ 8.62 RVUs) plus the existing radiological S&I code for balloon angioplasty (75962 @ 0.54 RVUs) plus one catheterization code that would be used for this procedure, typically 36247 (6.29 RVUs).

Therefore, the typical current work RVUs for iliac angioplasty may be calculated as:

Tibial angioplasty		8.62
+ Radiologic S&I		0.54
+ Catheterization		3.15 (after multiple procedure reduction)
Total	=	12.31 RVUs for typical tibial angioplasty case

Thus, our current recommendation of 11.00 work RVUs for new code Z13 will represent an 11% reduction compared to the above component code reporting approach of this procedure using current 2010 RVUs.

Comparison with Key Reference Service 61640 – RVW 12.32
Key reference 61640 *Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel* was chosen by 16 survey respondents. Code 61640 has an RVW of 12.32, intra service time of 90. This reference service is clinically analogous in that it describes catheterization of third order vessels, fluoroscopy, and road-mapping of vessels that are at a significant distance from the access site. Multiple catheter and guidewire exchanges are required adding to the length and complexity of these procedures. Angioplasty in both settings requires prolonged inflation times, removal of angioplasty balloons, re-evaluation of the treated lesion, and repeat angioplasty. Prolonged angioplasty for vasospasm is

necessary as it is in tibial angioplasty, but the treatment length of the tibial vessel is 5-10 times longer. While it can be argued that working in the intracranial bed is more intense, those vessels are typically free of atherosclerotic plaque of the thickness and irregularity of that encountered in the peripheral vascular disease patient, and the likelihood for distal embolization is greater in the peripheral vascular patient. Thus, our Consensus Panel and survey respondents felt that there is equivalence of intensity between 37228 and 61640.

An estimate for the RVW of 37228 can be established by considering this reference. Pre-service work of 61640 is 1.44 compared to 1.00(-0.44) for 37228. Post-service work of 61640 is 1.34 compared to 0.67 for 37228 (-0.67). Intra-service work is the same. Thus, an RVW for the new service can be estimated as:

Ref code 61640	12.32
Pre-service	-0.44
Intra-service	0.00
Post-service	-0.67
Total Service	**11.21**

Comparison with MPC CPT 92980 – RVW 14.82

This code was chosen as the key reference service in subsequent SoRs for this family. This MPC code has 120 minutes of intra service in comparison to 90 minutes for 37228 with 90. The IWPUT is slightly less intense at 0.1039 compared to 0.106. As mentioned above, both of these 0-day global percutaneous interventions are similarly intense throughout their performance though the tibial bed is 5-10 longer in potential treatment length than the coronary bed. If the deduction for difference in intra service time (30 minutes) is multiplied by the IWPUT, the reduction of 3.117 is obtained with a calculated RVW of the new code of 11.7.

Comparison with Clinically Relevant Service CPT 37215 Carotid Stent – RVW 19.68

Our Consensus Panel felt that CPT 37215 Carotid Stent placement would have been a perfect service to enter on the Reference Service List, save for the fact that it is a 90-day global service. We felt that survey respondents would not be able to perform the associated mathematics to carve away the post-service visits in order to derive an accurate comparison to the 0-day global service we are evaluating. However, the Consensus Panel readily performed this math based on the UC database, and 37215 becomes an excellent service on which to assess the value of the new code.

37215 was valued by the RUC in 2004. It has an RVW of 19.68, and of this total, 4.51 RVUs derive from post-procedural visits that would not be part of a 0-day global. Thus, the 0-day comparison value of 37215 would be 19.68 – 4.51 = 15.07. The pre-service time of 37215 is 75 minutes evaluation plus 15 minutes SDW, together representing 1.80 RVUs. The pre-service time of 37228 is 43 min evaluation plus 5 min SDW, representing 1.00 RVUs, thus we need to subtract 0.80 RVUs from 15.07 to adjust for pre-time, or 15.07-0.80 = 14.23. 37215 has an intra service time of 103 minutes. Our respondents reported a median intra service time of 90 minutes. The difference in RVW can be derived as 13 minutes x IWPUT (0.1223) = 1.59 RVW. Therefore, the calculated RVW of 37228 can be derived as 14.23 – 1.59 = 12.64

Services Reported with multiple CPT codes

The typical tibial/peroneal angioplasty will be reported with one code, and that is why we checked "no" to the question below about services reported with multiple CPT codes. However, if the patient has not undergone a recent diagnostic angiographic exam, and if all other criteria for a diagnostic study were met, the appropriate diagnostic arteriography code(s) could be added. Likewise, providers who require ultrasound guidance to gain arterial access could also report CPT 76937 (RVW 0.30) as long as they meet they documentation requirements of that code.

IWPUT

IWPUT of 37228 tibial balloon angioplasty is 0.106 with inputs as noted above. This is typical for high intensity percutaneous services that do not include lower intensity opening and closing time as in some surgical operations. This IWPUT also lies well within the range of the current proposal and existing IWPUTS for vascular intervention. For example:

Service	RUC Year	IWPUT
36821 open wrist AV fistula	2008	0.083
37228 Tibial PTA	**new**	**0.103**
92980 Coronary stent	1994	0.105
37182 TIPS	2002	0.105
61640 Intracranial PTA	2005	0.106
37215 Carotid stent	2004	0.122

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 35470, 75962, 36247

How often do physicians 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 surgery How often? Commonly

Specialty radiology How often? Commonly

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. Unable to estimate National frequency.

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 10,090 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached table for estimated Medicare frequency.

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 92982

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:37229 Tracking Number Z14 Specialty Society Recommended RVU: **14.05**

Global Period: 000 RUC Recommended RVU: **14.05**

CPT Descriptor: Revascularization, tibial/peroneal artery, unilateral, initial vessel; with atherectomy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old diabetic male presents with a non-healing ulcer of the right foot. Diagnostic studies reveal severe trifurcation (tibial/peroneal)disease. The posterior tibial and peroneal arteries are totally occluded. The anterior tibial artery has a segment of occlusion in the mid calf extending over 5 cm. Treatment of the initial vessel will be with an atherectomy.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 85%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 81%

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

Description of Pre-Service Work: Based on patient symptoms, signs, physical findings and pre-procedural studies, the physician estimates the range of guiding catheters, selective catheters, sheaths, guidewires, and balloons that may be required, and ensure availability. The need for stand-by devices that might be needed emergently (eg, stents and covered stents) is assessed. Results of preadmission testing are reviewed, with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Patient is reexamined to make sure that physical findings have not changed and H&P is updated. Procedure detail plan, including alternatives and risks, is discussed with patient and family. Informed consent is obtained for procedure and conscious sedation. Physician marks access sites. He or she checks interventional suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Physician ensures all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with all required devices. Physician ensures the patient is appropriately positioned on the table and intravenous access has been achieved. Physician dons radiation protection gear and ensures that all who will be in the interventional suite do likewis He or she upervises sterile prep of access site(s) and subsequent draping. A pre-procedural "time-out"is performed.

Description of Intra-Service Work: Conscious sedation is administered and adequate conscious sedation monitoring is verified. Physical exam and fluoroscopy are used to localize the vessel and level for access. The access vessel is cannulated

either percutaneously or with open exposure of the vessel, and an initial sheath is placed at the arteriotomy. A catheter and guidewire are manipulated proximal to the diseased tibial/peroneal artery using fluoroscopic guidance. Roadmapping images are obtained for vessel sizing and to document anatomy. Exchange of initial sheath and guidewire are performed with new guiding sheath, exchange length crossing wire, and crossing catheter positioned. If the occlusion cannot be rossed, a re-entry device (outback), or forceps (front runner) is exchanged in place of the selective catheter to recanalize he occlusion. It may be appropriate to place a distal embolic protection device, which may require pre-dilatation of a tight stenosis or occlusion. An atherectomy may be performed primarily or secondarily. Based on vessel measurements, an appropriate atherectomy device is chosen and is advanced into the diseased segment(s) and positioned using fluoroscopic guidance and contrast injection. Multiple passes are made with the atherectomy device, physically removing plaque from the vessel. The atherectomy catheter may require periodic removal from the vessel to empty the collection chamber of accumulated plaque. It is then introduced into the vessel again over the wire and the process is repeated until the desired amount of plaque has been debulked. Atherectomy may be done in conjunction with balloon angioplasty, either in the same segment of the vessel or in separate segments of the vessel, depending on anatomy and pathology present. Imaging is performed after the atherectomy. If the lesion has been satisfactorily opened, angioplasty would not be performed at that level. If the lesion is incompletely opened, it could be treated further with additional atherectomy or with balloon angioplasty. An appropriately sized angioplasty balloon catheter is advanced to the area of stenosis and is positioned using fluoroscopic guidance, and then is inflated to the appropriate pressure and time. The balloon is removed or pulled back over the wire, and follow-up images are obtained with contrast injection to determine if the stenosis has been adequately treated. Multiple balloon inflations may be required, or additional balloons with larger or smaller diameters may be used. If there are multiple segments of disease within the same tibial/peroneal artery, these are also treated with appropriate-sized balloon(s). Once a satisfactory result has been documented in the absence of extravasation or embolization, the embolic protection device is retrieved if used, the sheath is removed, and hemostasis obtained with manual compression, closure device, or surgical closure of the arteriotomy.

Description of Post-Service Work: Sterile dressings are applied. As needed, physician assists team in moving patient to stretcher. Post-procedure care is discussed with recovery area staff. Physician writes post-procedure orders for care and pain medication. He or she writes brief procedure note, and records contrast volume and radiation exposure time. Physician reviews all films and dictates interpretation. The patient exam and assessment of vital signs and perfusion of eated limb multiple times in recovery area is repeated, as needed. Physician monitors groin puncture site for hematoma. He or she discusses findings and treatment with family and patient (when awake). Physician writes orders for follow-up labs, x-rays. All appropriate medical records are completed, with copy to referring physician.

Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, x-rays, and patient care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010					
Presenter(s):	Joseph Babb, MD; David Han, MD; Clifford Kavinsky, MD; Arthur Lee, MD; Geraldine McGinty, MD; Gerald Niedzwiecki, MD; Gary Seabrook, MD; Mathew Sideman, MD; Zeke Silva, MD; Gregory Thomas, MD; Sean Tutton, MD; Robert Vogelzang, MD; Robert Zwolak, MD					
Specialty(s):	Cardiology; Vascular Surgery; Radiology					
CPT Code:	37229					
Sample Size:	600	**Resp N:**	68	**Response:** 11.3 %		
Sample Type:	Random	**Additional Sample Information:** random and panel				
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	1.00	**3.00**	8.00	90.00
Survey RVW:		7.10	11.00	**14.05**	15.94	21.00
Pre-Service Evaluation Time:				**70.00**		
Pre-Service Positioning Time:				**10.00**		
Pre-Service Scrub, Dress, Wait Time:				**15.00**		
Intra-Service Time:		50.00	90.00	**120.00**	150.00	250.00
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: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	37229	**Recommended Physician Work RVU: 14.05**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**33.00**	**7.00**
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:		**120.00**		
Immediate Post Service-Time:	**30.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**		
Discharge Day Mgmt:	**0.00**	99238x **0.0** 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

'ew Technology/Service:
ıs this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92980	000	14.82	**RUC Time**

CPT Descriptor Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
92980	000	14.00	**RUC Time**	326,038

CPT Descriptor 1 Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

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

'PT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
37215	090	19.68	**RUC Time**

CPT Descriptor Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal protection

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 25.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 37229**	**Key Reference CPT Code:** 92980	**Source of Time** RUC Time
Median Pre-Service Time	48.00	45.00	
Median Intra-Service Time	120.00	120.00	
'edian Immediate Post-service Time	30.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Total Time	**198.00**	**225.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.80	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.70	3.50
Urgency of medical decision making	3.50	3.40
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.40	3.90
Physical effort required	4.10	3.60
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.30	3.90
Outcome depends on the skill and judgment of physician	4.30	3.80
Estimated risk of malpractice suit with poor outcome	4.10	3.50

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.40	3.10
Intra-Service intensity/complexity	4.50	3.90
Post-Service intensity/complexity	3.20	2.90

Additional Rationale and Comments

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

Why is this Code Being Presented to the RUC?
The family of percutaneous interventional codes was identified by the RUC 5-Year Review Identification Workgroup for higher than anticipated increase in volume.

What is the "big picture" overview of this multiple code procedure?
The family includes four possible treatment modalities (angioplasty, stenting, atherectomy, stenting plus atherectomy) that can be used in three arterial beds (iliac, femoropopliteal, tibial). This SoR represents atherectomy with angioplasty in the tibial arterial bed.

The New Codes Bundle selective catheterization, intervention and radiological S&I
Currently, all percutaneous vascular intervention procedures are reported with the component coding approach, meaning that at least, three codes are used to report each treatment at any single level in the arterial tree. The basic three codes currently include 1) a selective catheterization code, plus 2) a treatment code, plus 3) a radiological supervision and interpretation code. In contrast, the new codes in this family BUNDLE all three of these steps into a single code. Thus, new code 37229 will REPLACE the use of, at a minimum, a code such as 36245 (selective catheterization) plus 37205 (non-coronary stent) plus 75960 (peripheral stent S&I).

Pre-service Time has been Substantially Reduced From Survey Data
Patients requiring vascular intervention are typically older and have multiple medical co-morbidities. In order to have tibial disease sufficiently severe to require treatment, the vignette patient probably has 50-100 pack-year of smoking, diabetes, and he almost certainly has an element of coronary disease and COPD. These patients move slowly with painful feet and require lots of TLC in order to obtain appropriate informed consent and accomplish all other pre-service tasks as well as conscious sedation. The survey respondents median pre-service evaluation time was 65 minutes with 13 minutes of scrub, dress and wait, for a total of 78 minutes. Our consensus panel voted to reduce the survey pre-time by 36% to 40 minutes of pre-service evaluation time, 3 minutes of positioning time, and 5 minutes of scrub/dress/wait time. We recommend starting with pre-service package 2B. We believe it is fully justified to add 7 minutes to pre-service evaluation to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging necessary for the procedure, and to coordinate all technical personnel. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views to treat the lesion in question.

How is tibial atherectomy and angioplasty Currently Reported and Valued?
Component coding is used currently to report this procedure. The primary procedure is assigned full RVU value while subsequent 0-, 10-, and 90-day global procedures receive a 50% multiple procedure payment reduction. XXX radiological supervision and interpretation codes are not subject to a multiple procedure payment reduction. The procedure that will soon be reported with 372X1 is currently reported with the existing stent code (35495 @ 9.48 RVUs) plus the existing radiological S&I code for peripheral atherectomy. (75992 @ 0.54 RVUs) plus the catheterization code that would be used for this procedure (36247@ 6.29) cut by 50% = 3.15In addition, we believe many of today's providers will additionally report a balloon angioplasty and balloon angioplasty S&I during an iliac stent procedure (35470 @ 8.62 RVUs cut by 50% for multiple procedure = 4.31 plus 75962 @ 0.54 for the angioplasty S&I).

Thus, a common current coding scenario could result in the following RVUs:

Tibial atherect.	9.48	
tibial angioplasty	4.31	(after multiple procedure payment reduction)
Angioplasty S&I	0.54	
Artherectomy S&I	0.54	
Catheterization	3.15	(after multiple procedure payment reduction)
Total	= 18.02 RVUs that may be reported for tibial atherectomy and angioplasty.	

Thus, our current median survey recommendation of 14.05 work RVUs for new code Z14 would represent a 20 % reduction compared to this component code reporting approach using current 2010 RVUs.

Comparison with Key Reference Service 92980 – RVW 14.82
Transcatheter placement of intra coronary stent . 92980 is a 0-day global RUC surveyed and valued code MPC code, with RVW of 14.82. With the exception of the Tibial PTA only code Z13, this was most often chosen as the key reference code for the remainder of the tibial base codes Z14-16. 92980 has 45 minutes of pre-service time compared to 48 minutes for the new code, so that is essentially equivalent. 93980 has an equivalent 120 minutes of intra-service time to the median survey response time of the new code 37229 and an IWPUT of 0.1039. This service is analogous as it describes, access, catheterization of a remote vascular bed (100-120 cm) with selection across stenoses of small caliber 2-4 mm vessels. Again while one can argue intensity, the vessels and treatment zones are shorter in the coronary bed, and longer in the tibial bed with same obligate catheter exchanges, long length guidewires, multiple and sometimes prolonged inflations of the angioplasty balloon, pressure measurements, and follow-up angiography.
A modest downward adjustment must be made for reduced post-service time as 92980 has 60 minutes of post-time compared to 30 minutes for the new code 37229. Post-service work of 92980 is 1.34 RVUs, and this must be reduced by 50% to represent the new code, so this difference is 0.62 RVUs. Thus, the calculated RVW for the new code relative to the reference code can be calculated as: 14.82 – 0.62 = 14.18.

Comparison with Clinically Relevant Service CPT 37215 Carotid Stent – RVW 19.68
Our Consensus Panel felt that CPT 37215 Carotid Stent placement would have been a perfect service to enter on the Reference Service List, save for the fact that it is a 90-day global service. We felt that survey respondents would not be able to perform the associated mathematics to carve away the post-service visits in order to derive an accurate comparison to the 0-day global service we are evaluating. However, the Consensus Panel readily performed this math based on the RUC database, and 37215 becomes an excellent service on which to assess the value of the new code.

37215 was valued by the RUC in 2004. It has an RVW of 19.68, and of this total, 4.51 RVUs derive from post-procedural visits that would not be part of a 0-day global. Thus, the 0-day comparison value of 37215 would be 19.68 – 4.51 = 15.07. The pre-service time of 37215 is 75 minutes evaluation plus 15 minutes SDW, together representing 1.80 RVUs. The pre-service time of 372X8 is 43 min evaluation plus 5 min SDW, representing 1.00 RVUs, thus we need to subtract 0.80 RVUs from 15.07 to adjust for pre-time, or 15.07-0.80 = 14.23. 37215 has an intra service time of 103 minutes. Our respondents reported a median intra service time of 120 minutes. The difference in RVW can be derived as +17 minutes x IWPUT (0.103) = 1.75 RVW.
Therefore, the calculated RVW of 37229 can be derived as 14.23 + 1.75 = 15.98

Comparison with Clinically Relevant CPT 37182 Transvenous Intrahepatic Portosystemic Shunt (TIPS)
Another clinically relevant comparison is CPT 37182 TIPS, which was valued by the RUC in 2002. TIPS is a 0-day global service with RVW 16.97, comprised of 30 minutes pre-time (0.60 RVUs) plus 150 minutes intra-time (15.70 RVUs) and 30 minutes post-time (0.60 RVUs). The main adjustment to draw a valid comparison lies in intra-service work. 37229 is 30 minutes shorter, and equivalent in intensity IWPUT of 0.103. Thus, a 30 minute time adjustment x the IWPUT (0.103) yields a reduction in intra-service work of 3.09. Pre-service adjustment adds 0.40 back to 37229

In summary, starting with 16.97 work RVUs for the 0-day global service 37182, we can estimate the value for 37229 by removing 3.09 intra-service work RVUs and adding 0.40 RVUs for pre-service, for an estimated value of 14.28 RVUs for the new service. This clinically relevant comparison also serves to validate our recommendation of the median survey 14.05 RVUs for 37229.

Services Reported with multiple CPT codes
The typical tibial/peroneal angioplasty will be reported with one code, and that is why we checked "no" to the question below about services reported with multiple CPT codes. However, if the patient has not undergone a recent diagnostic angiographic exam, and if all other criteria for a diagnostic study were met, the appropriate diagnostic arteriography code(s) could be added. Likewise, providers who require ultrasound guidance to gain arterial access could also report CPT 76937 (RVW 0.30) as long as the meet they documentation requirements of that code.

IWPUT

IWPUT of 372X8 tibial balloon angioplasty is 0.106 with inputs as noted above. This is typical for high intensity percutaneous services that do not include lower intensity opening and closing time as in some surgical operations. This IWPUT also lies well within the range of the current proposal and existing IWPUT for vascular intervention. For example:

Service	RUC Year	IWPUT
36821 open wrist AV fistula	2008	0.083
37229 Tibial ath/PTA	**New**	**0.103**
92980 Coronary stent	1994	0.105
37182 TIPS	2002	0.105
61640 Intracranial PTA	2005	0.106
37215 Carotid stent	2004	0.122

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 35495 75992 36247 35470 75962

How often do physicians 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 surgery How often? Commonly

Specialty radiology How often? Commonly

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. Unable to estimate National frequency.

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 9,062
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached table for estimated Medicare frequency.

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 92980

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:37230 Tracking Number Z15 Specialty Society Recommended RVU: **13.80**

Global Period: 000 RUC Recommended RVU: **13.80**

CPT Descriptor: Revascularization, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old diabetic male presents with gangrene of the right 2nd and 3rd toes. He has had a prior BKA on the left. Diagnostic studies reveal severe trifurcation (tibial/peroneal artery) disease. The posterior tibial and peroneal arteries are totally occluded. The anterior tibial artery has a segment of occlusion in the mid calf with reconstitution distally and patency of the dorsalis pedal artery. Treatment of the initial vessel will be with stent.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 90%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 63%

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

Description of Pre-Service Work: Based on patient symptoms, signs, physical findings and pre-procedural studies, the physician estimates the range of guiding catheters, selective catheters, sheaths, guidewires, balloons, and stents that may be required, and ensure availability. Physician then assess the need for stand-by devices that might be needed emergently (eg, covered stents). Results of preadmission testing are reviewed, with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Physician reexamines patient to make sure that physical findings have not changed, and updates H&P. The procedure detail plan is discussed, including alternatives and risks, with patient and family. Informed consent is obtained for procedure and conscious sedation. Physician marks access sites. The interventional suite is checked to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Physician ensures that all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with all required devices. The patient is appropriately positioned on the table and the physician ensures that intravenous access has been achieved. Physician dons radiation protection gear and ensures that all who will be in the interventional suite do likewise. He or she supervises sterile prep of access site(s) and subsequent draping. A pre-procedural "time-out" is performed.

Description of Intra-Service Work: Conscious sedation is administered and adequate conscious sedation monitoring is verified. Physical exam and fluoroscopy are used to localize the vessel and level for access. The access vessel is cannulated either percutaneously or with open exposure of the vessel, and an initial sheath is placed at the arteriotomy. A catheter and guidewire are manipulated proximal to the diseased tibial/peroneal artery using fluoroscopic guidance. Roadmapping images are obtained for vessel sizing and to document anatomy. Exchange of initial sheath and guidewi are performed with new guiding sheath, exchange length crossing wire, and crossing catheter positioned. If the occlusio cannot be crossed, a re-entry device (outback), or forceps (front runner) is exchanged in place of the selective catheter to recanalize the occlusion. The lesion may be initially treated with balloon angioplasty, either as an intended primary therapy, or as pre-dilatation to allow passage of the stent delivery system. If the stent is intended as the primary therapy, an appropriately sized stent is selected and introduced to the lesion through the sheath. Using fluoroscopic guidance and appropriate roadmapping, the stent is positioned across the intended treatment zone, and is deployed, either by placement of a self-expanding stent or balloon-expandable stent. The stent may be seated or fully opened with additional angioplasty. The stent delivery system and balloon are removed or pulled back over the wire, and follow-up images are obtained with contrast injection to determine if the stenosis has been adequately treated and to exclude dissection or extravasation. Multiple balloon inflations may be required, or additional balloons with larger or smaller diameters may be used. If it was intended that the primary therapy for the lesion was to be balloon angioplasty, but that fails to open the lesion or results in dissection or other complication, a stent is then introduced into the vessel and is deployed to achieve patency of the lesion. If there are multiple segments of disease within the ipsilateral tibial/peroneal artery segments, these are also treated with appropriate-sized stent(s) and/or balloons. Once a satisfactory result has been documented in the absence of extravasation or embolization, the embolic protection device is retrieved if used, the sheath is removed, and hemostasis obtained with manual compression, closure device, or surgical closure of the arteriotomy.

Description of Post-Service Work: Sterile dressings are applied. As needed, physician assists team in moving patient to stretcher. Post-procedure care is discussed with recovery area staff. Physician writes post-procedure orders for care and pain medication. He or she writes brief procedure note, and records contrast volume and radiation exposure time. Physician reviews all films and dictates interpretation. The patient exam and assessment of vital signs and perfusion of treated limb multiple times in recovery area is repeated, as needed. Physician monitors groin puncture site for hematoma. He or she discusses findings and treatment with family and patient (when awake). Physician writes orders for follow-ur labs, x-rays. All appropriate medical records are completed, with copy to referring physician.

Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, x-rays, and patient care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Joseph Babb, MD; David Han, MD; Clifford Kavinsky, MD; Arthur Lee, MD; Geraldine McGinty, MD; Gerald Niedzwiecki, MD; Gary Seabrook, MD; Mathew Sideman, MD; Zeke Silva, MD; Gregory Thomas, MD; Sean Tutton, MD; Robert Vogelzang, MD; Robert Zwolak, MD				
Specialty(s):	Cardiology; Vascular Surgery; Radiology				
CPT Code:	37230				
Sample Size:	600	**Resp N:**	72	**Response:** 12.0 %	
Sample Type:	Random	**Additional Sample Information:**	random and panel		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**3.00**	6.00	180.00
Survey RVW:	6.74	10.00	**13.80**	15.00	25.00
Pre-Service Evaluation Time:			**65.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	45.00	90.00	**120.00**	150.00	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):	**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:	37230	**Recommended Physician Work RVU: 13.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**33.00**	**7.00**
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:		**120.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 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
92980	000	14.82	**RUC Time**

CPT Descriptor Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
92980	000	14.82	**RUC Time**	326,038

CPT Descriptor 1 Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

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
37215	090	19.68	**RUC Time**

CPT Descriptor Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 26.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 37230**	**Key Reference CPT Code: 92980**	**Source of Time RUC Time**
Median Pre-Service Time	48.00	45.00	
Median Intra-Service Time	120.00	120.00	
Median Immediate Post-service Time	30.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Total Time	**198.00**	**225.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.92	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.83
Urgency of medical decision making	4.00	3.92
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.67	4.42
Physical effort required	4.25	3.92
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.42	4.17
Outcome depends on the skill and judgment of physician	4.75	4.58
Estimated risk of malpractice suit with poor outcome	4.17	3.92

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.67	3.67
Intra-Service intensity/complexity	4.75	4.42
Post-Service intensity/complexity	3.50	3.42

Additional Rationale and Comments

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

Why is this Code Being Presented to the RUC?
The family of percutaneous interventional codes was identified by the RUC 5-Year Review Identification Workgroup for higher than anticipated increase in volume.

What is the "big picture" overview of this multiple code procedure?
The family includes four possible treatment modalities (angioplasty, stenting, atherectomy, stenting plus atherectomy) that can be used in three arterial beds (iliac, femoropopliteal, tibial). This SoR represents stent with or without angioplasty in the tibial arterial bed.

The New Codes Bundle selective catheterization, intervention and radiological S&I
Currently, all percutaneous vascular intervention procedures are reported with the component coding approach, meaning that at least, three codes are used to report each treatment at any single level in the arterial tree. The basic three codes currently include 1) a selective catheterization code, plus 2) a treatment code, plus 3) a radiological supervision and interpretation code. In contrast, the new codes in this family BUNDLE all three of these steps into a single code. Thus, new code 37230 will REPLACE the use of, at a minimum, a code such as 36245 (selective catheterization) plus 37205 (non-coronary stent) plus 75960 (peripheral stent S&I).

Pre-service Time has been Substantially Reduced From Survey Data
Patients requiring vascular intervention are typically older and have multiple medical co-morbidities. In order to have tibial disease sufficiently severe to require treatment, the vignette patient probably has 50-100 pack-year of smoking, diabetes, and he almost certainly has an element of coronary disease and COPD. These patients move slowly with painful feet and require lots of TLC in order to obtain appropriate informed consent and accomplish all other pre-service tasks as well as conscious sedation. The survey respondents median pre-service evaluation time was 65 minutes with 13 minutes of scrub, dress and wait, for a total of 78 minutes. Our consensus panel voted to reduce the survey pre-time by 36% to 40 minutes of pre-service evaluation time, 3 minutes of positioning time, and 5 minutes of scrub/dress/wait time. We recommend starting with pre-service package 2B. We believe it is fully justified to add 7 minutes to pre-service evaluation to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging necessary for the procedure, and to coordinate all technical personnel. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views to treat the lesion in question.

How is tibial/ peroneal stent Currently Reported and Valued?
Component coding is used currently to report this procedure. The primary procedure is assigned full RVU value while subsequent 0-, 10-, and 90-day global procedures receive a 50% multiple procedure payment reduction. XXX radiological supervision and interpretation codes are not subject to a multiple procedure payment reduction. The procedure that will soon be reported with 37230 is currently reported with the existing stent code (37205 @ 8.27 RVUs) plus the existing radiological S&I code for peripheral stent (75960 @ 0.82 RVUs) plus selective catheterization 36247 @ 6.29 cut by 50% for multiple procedure = 3.15. In addition, we believe many of today's providers will additionally report a balloon angioplasty and balloon angioplasty S&I during a tibial stent procedure as stenting is often a bailout for failed angioplasty thus (35470 @ 8.62 RVUs cut by 50% for multiple procedure = 4.31 plus 0.54 for the angioplasty S&I)

Thus, a common current coding scenario could result in the following RVUs:

Tibial stent	8.27	
Stent S&I	0.82	
tibial angioplasty	4.31	(after multiple procedure payment reduction)
Angioplasty S&I	0.54	
Catheterization	3.15	(after multiple procedure payment reduction)
Total =	17.09 RVUs that may be reported for placement of an tibial/peroneal stent.	

Thus, our current median survey recommendation of 13.80 work RVUs for new code Z15 (37230) would represent a 1 % reduction compared to this component code reporting approach using current 2010 RVUs.

Comparison with Key Reference Service 92980 – RVW 14.82
Transcatheter placement of intra coronary stent . 92980 is a 0-day global RUC surveyed and valued code MPC code, with RVW of 14.82. With the exception of the Tibial PTA only code Z13, this was most often chosen as the key reference code for the remainder of the tibial base codes Z14-16. 92980 has 45 minutes of pre-service time compared to 8 minutes for the new code, so that is essentially equivalent. 92980 has an equivalent 120 minutes of intra-service time to the median survey response time of the new code 37230 and an IWPUT of 0.1039. This service is analogous as it describes, access, catheterization of a remote vascular bed (100-120 cm) with selection across stenoses of small caliber 2-4 mm vessels, followed by angioplasty and stent placement. Again while one can argue intensity, the vessels and treatment zones are shorter in the coronary bed, and longer in the tibial bed with same obligate catheter exchanges, long length guidewires, multiple and sometimes prolonged inflations of the angioplasty balloon, stent deployement, pressure measurements, and follow-up angiography. A modest downward adjustment must be made for reduced post-service time as 92980 has 60 minutes of post-time compared to 30 minutes for the new code 37230.
Post-service work of 92980 is 1.34 RVUs, and this must be reduced by 50% to represent the new code, so this difference is 0.62 RVUs. Thus, the calculated RVW for the new code relative to the reference code can be calculated as: 14.82 – 0.62 = 14.18. This is analogous work with strikingly similar RVWs

Comparison with Clinically Relevant Service CPT 37215 Carotid Stent – RVW 19.68
Our Consensus Panel felt that CPT 37215 Carotid Stent placement would have been a perfect service to enter on the Reference Service List, save for the fact that it is a 90-day global service. We felt that survey respondents would not be able to perform the associated mathematics to carve away the post-service visits in order to derive an accurate comparison to the 0-day global service we are evaluating. However, the Consensus Panel readily performed this math based on the RUC database, and 37215 becomes an excellent service on which to assess the value of the new code.

37215 was valued by the RUC in 2004. It has an RVW of 19.68, and of this total, 4.51 RVUs derive from post-procedural visits that would not be part of a 0-day global. Thus, the 0-day comparison value of 37215 would be 19.68 – 4.51 = 15.07. The pre-service time of 37215 is 75 minutes evaluation plus 15 minutes SDW, together representing 1.80 RVUs. The pre-service time of 372X8 is 43 min evaluation plus 5 min SDW, representing 1.00 RVUs, thus we need to subtract 0.80 RVUs from 15.07 to adjust for pre-time, or 15.07-0.80 = 14.23. 37215 has an intra service time of 103 minutes. Our respondents reported a median intra service time of 120 minutes for 37230. The difference in RVW can be derived as +17 minutes x IWPUT (0.103) = 1.75 RVW. Therefore, the calculated RVW of 372x9 can be derived as 14.23 + 1.75 = 15.98

Comparison with Clinically Relevant CPT 37182 Transvenous Intrahepatic Portosystemic Shunt (TIPS)
Another clinically relevant comparison is CPT 37182 TIPS, which was valued by the RUC in 2002. TIPS is a 0-day global service with RVW 16.97, comprised of 30 minutes pre-time (0.60 RVUs) plus 150 minutes intra-time (15.70 RVUs) and 30 minutes post-time (0.60 RVUs). The main adjustment to draw a valid comparison lies in intra-service work. 37230 is 30 minutes shorter, and equivalent in intensity IWPUT of 0.101. Thus, a 30 minute time adjustment x the IWPUT (0.101) yields a reduction in intra-service work of 3.03. Pre-service adjustment adds 0.40 back to 37230

In summary, starting with 16.97 work RVUs for the 0-day global service 37182, we can estimate the value for 37230 by removing 3.03 intra-service work RVUs and adding 0.40 RVUs for pre-service, for an estimated value of 14.37 RVUs for the new service. This clinically relevant comparison also serves to validate our recommendation of the median survey 13.80 RVUs for 37230.

Services Reported with multiple CPT codes
The typical tibial/peroneal stent procedure will be reported with one code, and that is why we checked "no" to the question below about services reported with multiple CPT codes. However, if the patient has not undergone a recent diagnostic angiographic exam, and if all other criteria for a diagnostic study were met, the appropriate diagnostic arteriography code(s) could be added. Likewise, providers who require ultrasound guidance to gain arterial access could also report CPT 76937 (RVW 0.30) as long as the meet they documentation requirements of that code.

IWPUT

IWPUT of 37230 at the median survey recommended RVW is 0.101. This value is typical for complex intra-arterial work, both open and percutaneous. This IWPUT also lies well within the range of the current proposal and existing IWPUTS for vascular intervention. For example:

Service	RUC Year	IWPUT
36821 open wrist AV fistula	2008	0.083
37230 Tibial Stent/PTA	**New**	**0.101**
92980 Coronary stent	1994	0.105
37182 TIPS	2002	0.105
61640 Intracranial PTA	2005	0.106
37215 Carotid stent	2004	0.122

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37205 75960 36247 35470 75962

How often do physicians 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 surgery How often? Commonly

Specialty radiology How often? Commonly

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. Unable to estimate National frequency.

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 15,740 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached table for estimated Medicare frequency.

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 34833

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:37231 Tracking Number Z16 Specialty Society Recommended RVU: **15.00**

Global Period: 000 RUC Recommended RVU: **15.00**

CPT Descriptor: Revascularization, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old diabetic male presents with gangrene of the right 2nd and 3rd toes. He has had a prior BKA on the left. Diagnostic studies reveal severe trifurcation (tibial/peroneal artery) disease. The posterior tibial and peroneal arteries are totally occluded. The anterior tibial artery has a segment of occlusion in the mid to distal calf with reconstitution at the ankle, supplying the dorsalis pedal artery. Treatment of the initial vessel will require atherectomy and stent.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

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

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

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

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

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 90%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 69%

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

Description of Pre-Service Work: Based on patient symptoms, signs, physical findings and pre-procedural studies, the physician estimates the range of guiding catheters, selective catheters, sheaths, guidewires, balloons, and stents that may be required, and ensure availability. Physician then assess the need for stand-by devices that might be needed emergently (eg, covered stents). Results of preadmission testing are reviewed, with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Physician reexamines patient to make sure that physical findings have not changed, and updates H&P. The procedure detail plan is discussed, including alternatives and risks, with patient and family. Informed consent is obtained for procedure and conscious sedation. Physician marks access sites. The interventional suite is checked to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Physician ensures that all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with ε required devices. The patient is appropriately positioned on the table and the physician ensures that intravenous access has been achieved. Physician dons radiation protection gear and ensures that all who will be in the interventional suite do likewise. He or she supervises sterile prep of access site(s) and subsequent draping. A pre-procedural "time-out" is performed.

Description of Intra-Service Work: Conscious sedation is administered and adequate conscious sedation monitoring is verified. Physical exam and fluoroscopy are used to localize the vessel and level for access. The access vessel is annulated either percutaneously or with open exposure of the vessel, and an initial sheath is placed at the arteriotomy. A catheter and guidewire are manipulated proximal to the diseased tibial/peroneal artery using fluoroscopic guidance. Roadmapping images are obtained for vessel sizing and to document anatomy. Exchange of initial sheath and guidewire are performed with new guiding sheath, exchange length crossing wire, and crossing catheter positioned. If the occlusion cannot be crossed, a re-entry device (outback), or forceps (front runner) is exchanged in place of the selective catheter to recanalize the occlusion. It may be appropriate to place a distal embolic protection device, which may require pre-dilatation of a tight stenosis or occlusion. An atherectomy may be performed primarily or secondarily. Based on vessel measurements, an appropriate atherectomy device is chosen and is advanced into the diseased segment(s) and positioned using fluoroscopic guidance and contrast injection. Multiple passes are made with the atherectomy device, physically removing plaque from the vessel. The atherectomy catheter may require periodic removal from the vessel to empty the collection chamber of accumulated plaque. It is then introduced into the vessel again over the wire and the process is repeated until the desired amount of plaque has been debulked. Atherectomy may be done in conjunction with balloon angioplasty, either in the same segment of the vessel or in separate segments of the vessel, depending on anatomy and pathology present. Imaging is performed after the atherectomy. In the event of suboptimal atherectomy and angioplasty, a stent placement may be required. Using fluoroscopic guidance and appropriate roadmapping, stent length, diameter, and properties are chosen. The stent is positioned across the intended treatment zone, and is deployed. The stent may be seated or fully opened with additional angioplasty. The stent delivery system and balloon are removed or pulled back over the wire, and follow-up images are obtained with contrast injection to determine if the lesion has been adequately treated and to exclude dissection or extravasation. Once a satisfactory result has been documented in the absence of extravasation or embolization, the embolic protection device is retrieved if used, the sheath is removed, and hemostasis obtained with manual compression, closure device, or surgical closure of the arteriotomy.

Description of Post-Service Work: Sterile dressings are applied. As needed, physician assists team in moving patient to stretcher. Post-procedure care is discussed with recovery area staff. Physician writes post-procedure orders for care and ain medication. He or she writes brief procedure note, and records contrast volume and radiation exposure time. Physician reviews all films and dictates interpretation. The patient exam and assessment of vital signs and perfusion of treated limb multiple times in recovery area is repeated, as needed. Physician monitors groin puncture site for hematoma. He or she discusses findings and treatment with family and patient (when awake). Physician writes orders for follow-up labs, x-rays. All appropriate medical records are completed, with copy to referring physician.

Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, x-rays, and patient care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Joseph Babb, MD; David Han, MD; Clifford Kavinsky, MD; Arthur Lee, MD; Geraldine McGinty, MD; Gerald Niedzwiecki, MD; Gary Seabrook, MD; Mathew Sideman, MD; Zeke Silva, MD; Gregory Thomas, MD; Sean Tutton, MD; Robert Vogelzang, MD; Robert Zwolak, MD				
Specialty(s):	Cardiology; Vascular Surgery; Radiology				
CPT Code:	37231				
Sample Size:	600	**Resp N:**	67	**Response:** 11.1 %	
Sample Type:	Random	**Additional Sample Information:**	random and panel		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**2.00**	5.00	100.00
Survey RVW:	8.05	12.00	**15.00**	17.25	25.00
Pre-Service Evaluation Time:			**70.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	75.00	120.00	**135.00**	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):	**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:	37231	**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**	**33.00**	**7.00**
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:		**135.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
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
92980	000	14.82	**RUC Time**

CPT Descriptor Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
92980	000	14.82	**RUC Time**	326,038

CPT Descriptor 1 Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel

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
37215	090	19.68	**RUC Time**

CPT Descriptor Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 22.3 %

TIME ESTIMATES (Median)	**CPT Code: 37231**	**Key Reference CPT Code: 92980**	**Source of Time RUC Time**
Median Pre-Service Time	48.00	45.00	
Median Intra-Service Time	135.00	120.00	
Median Immediate Post-service Time	30.00	60.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Total Time	**213.00**	**225.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.71
Urgency of medical decision making	3.86	3.86
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.71	4.43
Physical effort required	4.29	3.86
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.29	4.14
Outcome depends on the skill and judgment of physician	4.57	4.29
Estimated risk of malpractice suit with poor outcome	4.00	3.71

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.43	3.29
Intra-Service intensity/complexity	4.86	4.29
Post-Service intensity/complexity	3.29	3.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Why is this Code Being Presented to the RUC?
The family of percutaneous interventional codes was identified by the RUC 5-Year Review Identification Workgroup for higher than anticipated increase in volume.

What is the "big picture" overview of this multiple code procedure?
The family includes four possible treatment modalities (angioplasty, stenting, atherectomy, stenting plus atherectomy) that can be used in three arterial beds (iliac, femoropopliteal, tibial). This SoR represents atherectomy, angioplasty and stent placement in the tibial arterial bed.

The New Codes Bundle selective catheterization, intervention and radiological S&I
Currently, all percutaneous vascular intervention procedures are reported with the component coding approach, meaning that at least, three codes are used to report each treatment at any single level in the arterial tree. The basic three codes currently include 1) a selective catheterization code, plus 2) a treatment code, plus 3) a radiological supervision and interpretation code. In contrast, the new codes in this family BUNDLE all three of these steps into a single code. Thus, new code 37231 will REPLACE the use of, at a minimum, a code such as 36245 (selective catheterization) plus 37205 (non-coronary stent) plus 75960 (peripheral stent S&I).

Pre-service Time has been Substantially Reduced From Survey Data
Patients requiring vascular intervention are typically older and have multiple medical co-morbidities. In order to have tibial disease sufficiently severe to require treatment, the vignette patient probably has 50-100 pack-year of smoking, diabetes, and he almost certainly has an element of coronary disease and COPD. These patients move slowly with painful feet and require lots of TLC in order to obtain appropriate informed consent and accomplish all other pre-service tasks as well as conscious sedation. The survey respondents median pre-service evaluation time was 65 minutes with 13 minutes of scrub, dress and wait, for a total of 78 minutes. Our consensus panel voted to reduce the survey pre-time by 36% to 40 minutes of pre-service evaluation time, 3 minutes of positioning time, and 5 minutes of scrub/dress/wait time. We recommend starting with pre-service package 2B. We believe it is fully justified to add 7 minutes to pre-service evaluation to account for selection and verification of numerous supplies and devices, review and set-up of significant imaging necessary for the procedure, and to coordinate all technical personnel. We recommend adding 2 minutes for appropriate positioning on the table in order to be able to obtain all appropriately necessary views to treat the lesion in question.

How is Tibial Atherectomy, PTA, and Stent Currently Reported and Valued?
Component coding is used currently to report this procedure. The primary procedure is assigned full RVU value while subsequent 0-, 10-, and 90-day global procedures receive a 50% multiple procedure payment reduction. XXX radiological supervision and interpretation codes are not subject to a multiple procedure payment reduction. The procedure that will soon be reported with 37231 is currently reported with the existing atherectomy code 35495 @ 9.48 RVUs reported with its radiological S&I code 75992 @ 0.54 in addition to the stent code (37205 @ 8.27 RVUs cut by 50% for multiple procedure = 4.14) plus the existing radiological S&I code for peripheral stent (75960 @ 0.82 RVUs) plus the catheterization code 36247 @ 6.29 cut by 50% = to 3.15 In addition, we believe many of today's providers will additionally report a balloon angioplasty and balloon angioplasty S&I during an iliac stent procedure (35473 @ 6.03 RVUs cut by 50% for multiple procedure = 3.02 plus 0.54 for the angioplasty S&I)

Thus, a common current coding scenario could result in the following RVUs:

Tibial atherect.	9.48	
Atherect. S&I	0.54	
Peripheral stent	4.14	(after multiple procedure payment reduction)
Stent S&I	0.82	
Tibial PTA	3.02	(after multiple procedure payment reduction)
Angioplasty S&I	0.54	
Catheterization	3.15	(after multiple procedure payment reduction)
otal =	21.69 RVUs that may be reported for tibial atherectomy, PTA, and stent.	

Thus, our current median survey recommendation of 15.00 work RVUs for new code Z16 would represent a 33 %reduction compared to this component code reporting approach using current 2010 RVUs.

Comparison with Key Reference Service 92980 – RVW 14.82

Transcatheter placement of intra coronary stent 92980 is a 0-day global RUC surveyed and valued code MPC code, with RVW of 14.82. With the exception of the Tibial PTA only code Z13, this was most often chosen as the key reference code for the remainder of the tibial base codes Z14-16. 92980 has 45 minutes of pre-service time compared to 48 minutes for the new code, so that it is essentially equivalent. 92980 has 120 minutes of intra-service time compared to a median survey response time for the new code 37231 of 135 minutes and an IWPUT of 0.100. As indicated in SoR for Z15 372x10, this service is analogous as it describes, access, catheterization of a remote vascular bed (100-120 cm) with selection across stenoses of small caliber 2-4 mm vessels, however there is additional work of atherectomy (reflected in the intraservice time), with concomitant angioplasty and stent placement. Again while one can argue intensity, the vessels and treatment zones are shorter in the coronary bed, and longer in the tibial bed with same obligate catheter exchanges, long length guidewires, multiple and sometimes prolonged inflations of the angioplasty balloon, stent deployement, pressure measurements, and follow-up angiography. The additional work of atherectomy relates to placement of distal protection device, selection of appropriate atherectomy device, passage and removal of device, plaque removal, and additional interval angiography.

Calculating for the additional intra-service time of 15 minutes x the IWPUT of 0.100 yields and additional 1.5 RVWs A modest downward adjustment must be made for reduced post-service time as 92980 has 60 minutes of post-time compared to 30 minutes for the new code 37231. Post-service work of 92980 is 1.34 RVUs, and this must be reduced by 50% to represent the new code, so this difference is 0.62 RVUs. Taking the reference code 92980 with 14.82 RVWs, the calculated RVW for the new code relative to the reference code can be calculated as: 14.82 – 0.62 + 1.5= 15.7. This corresponds well as the new code represents incremental work with strikingly similar intensity.

Comparison with Clinically Relevant Service CPT 37215 Carotid Stent – RVW 19.68

Our Consensus Panel felt that CPT 37215 Carotid Stent placement would have been a perfect service to enter on the Reference Service List, save for the fact that it is a 90-day global service. We felt that survey respondents would not be able to perform the associated mathematics to carve away the post-service visits in order to derive an accurate comparison to the 0-day global service we are evaluating. However, the Consensus Panel readily performed this math based on the RUC database, and 37215 becomes an excellent service on which to assess the value of the new code.

37215 was valued by the RUC in 2004. It has an RVW of 19.68, and of this total, 4.51 RVUs derive from post-procedural visits that would not be part of a 0-day global. Thus, the 0-day comparison value of 37215 would be 19.68 – 4.51 = 15.07. The pre-service time of 37215 is 75 minutes evaluation plus 15 minutes SDW, together representing 1.80 RVUs. The pre-service time of 372X8 is 43 min evaluation plus 5 min SDW, representing 1.00 RVUs, thus we need to subtract 0.80 RVUs from 15.07 to adjust for pre-time, or 15.07-0.80 = 14.23. 37215 has an intra service time of 103 minutes. Our respondents reported a median intra service time of 135 minutes for 37231. The difference in RVW can be derived as +32 minutes x IWPUT (0.100) = 3.2 RVW. Therefore, the calculated RVW of 37231 can be derived as 14.23 + 3.2 = 17.43

Comparison with Clinically Relevant CPT 37182 Transvenous Intrahepatic Portosystemic Shunt (TIPS)

Another clinically relevant comparison is CPT 37182 TIPS, which was valued by the RUC in 2002. TIPS is a 0-day global service with RVW 16.97, comprised of 30 minutes pre-time (0.60 RVUs) plus 150 minutes intra-time (15.70 RVUs) and 30 minutes post-time (0.60 RVUs). The main adjustment to draw a valid comparison lies in intra-service work. 37231 is 15 minutes shorter, and equivalent in intensity IWPUT of 0.101 vs. 0.100. Thus, a 15 minute time adjustment x the IWPUT (0.100) yields a reduction in intra-service work of 1.515. Pre-service adjustment adds 0.40 back to 37231

In summary, starting with 16.97 work RVUs for the 0-day global service 37182, we can estimate the value for 37231 by removing 1.515 intra-service work RVUs and adding 0.40 RVUs for pre-service, for an estimated value of 15.86 RVUs for the new service. This clinically relevant comparison also serves to validate our recommendation of the median survey 15.00 RVUs for 37231.

Services Reported with multiple CPT codes

The typical tibial/peroneal angioplasty, atherectomy and stent placement will be reported with one code, and that is why we checked "no" to the question below about services reported with multiple CPT codes. However, if the patient has not undergone a recent diagnostic angiographic exam, and if all other criteria for a diagnostic study were met, the ppropriate diagnostic arteriography code(s) could be added. Likewise, providers who require ultrasound guidance to gain arterial access could also report CPT 76937 (RVW 0.30) as long as the meet they documentation requirements of that code.

IWPUT

IWPUT of 37231 at the median survey recommended RVW is 0.100. This value is typical for complex intra-arterial work, both open and percutaneous. This IWPUT also lies well within the range of the current proposal and existing IWPUTS for vascular intervention. For example:

Service	RUC Year	IWPUT
36821 open wrist AV fistula	2008	0.083
372x10 Tib. athct./PTA Stent	**New**	**0.100**
92980 Coronary stent	1994	0.105
37182 TIPS	2002	0.105
61640 Intracranial PTA	2005	0.106
37215 Carotid stent	2004	0.122

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 35495 75992 37205 75960 36247 35473 75962

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
[c] the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Commonly

Specialty surgery How often? Commonly

Specialty radiology How often? Commonly

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. Unable to estimate National frequency.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,124
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached table for estimated Medicare frequency.

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? (ie. simila work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 92980

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:37232 Tracking Number Z17 Specialty Society Recommended RVU: **4.00**

Global Period: ZZZ RUC Recommended RVU: **4.00**

CPT Descriptor: Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old diabetic male presents with gangrene of the right 2nd and 3rd toes. Diagnostic studies reveal severe trifurcation (tibial/peroneal artery) disease. The posterior tibial artery is totally occluded. Both the peroneal and anterior tibial arteries are patent, but each have high-grade stenoses at the proximal calf level. Treatment of the second vessel is by angioplasty only. (Treatment of the initial vessel is separately coded.)

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

ercent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an &M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 92%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 68%

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: Patients who require interventional treatment at more than one site will obligatorily require an increment of additional pre-service evaluation work by the physician for completion of a thorough pre-procedural assessment. The physician needs to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, which order to proceed in, what approach to use, and what impact the second site will have on potential use of an embolic protection device.

Description of Intra-Service Work: This procedure could be performed through the same arteriotomy as was used for the base procedure 372X8. However, it could also be done from a separate access, in which case a suitable access vessel is again cannulated either percutaneously or with open exposure of the vessel, and a distinct sheath is placed (separately coded). Under fluoroscopic guidance and roadmapping, the additional tibial branch vessel is cannulated. Roadmapping nages are obtained for vessel sizing and to document anatomy. The area(s) of stenosis/occlusion are crossed with a guidewire, crossing catheter, re-entry, or forceps device as previously outlined. If lesions are being treated at a bifurcation, tandem wires may be used to cross stenoses at the origins of each vessel. It may be appropriate to place a distal embolic protection device. An atherectomy may be performed primarily or secondarily.An appropriately sized balloon angioplasty catheter is advanced to the area of stenosis and is positioned using fluoroscopic guidance, and then is inflated to the

appropriate pressure and time for opening of the lesion. The balloon is removed or pulled back over the wire, and follow-up images are obtained with contrast injection to determine if the stenosis has been adequately treated. Multiple balloon inflations may be required, or additional balloons with larger or smaller diameters may be used. Once a satisfactory result has been documented in the absence of extravasation or embolization, the embolic protection device is retrieved if used, the sheath is removed, and hemostasis obtained with manual compression, closure device, or surgical closure of th arteriotomy.

Description of Post-Service Work: Additional post-service work over and above that already provided for the primary procedure includes more time reviewing extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation to patient and family. More attention needs to be paid to the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Joseph Babb, MD; David Han, MD; Clifford Kavinsky, MD; Arthur Lee, MD; Geraldine McGinty, MD; Gerald Niedzwiecki, MD; Gary Seabrook, MD; Mathew Sideman, MD; Zeke Silva, MD; Gregory Thomas, MD; Sean Tutton, MD; Robert Vogelzang, MD; Robert Zwolak, MD				
Specialty(s):	Cardiology; Vascular Surgery; Radiology				
CPT Code:	37232				
Sample Size:	600	**Resp N:**	64	**Response:** 10.6 %	
Sample Type:	Random	**Additional Sample Information:**	random and panel		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**5.00**	10.00	150.00
Survey RVW:	2.14	4.00	**5.00**	6.58	11.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	30.00	**40.00**	60.00	180.00

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: ZZZ Global Code

CPT Code:	37232	**Recommended Physician Work RVU: 4.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**1.00**	**0.00**	**1.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**40.00**		

Immediate Post Service-Time:	**1.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
34826	ZZZ	4.12	**RUC Time**

CPT Descriptor Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code 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
35600	ZZZ	4.94	**RUC Time**	3,597

CPT Descriptor 1 Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63295	ZZZ	5.25	**RUC Time**	31

CPT Descriptor 2 Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (Lis. 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: 7 **% of respondents:** 10.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 37232**	**Key Reference CPT Code: 34826**	**Source of Time RUC Time**
Median Pre-Service Time	1.00	0.00	
Median Intra-Service Time	40.00	30.00	
Median Immediate Post-service Time	1.00	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	**42.00**	**30.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.75	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.75	3.50
Urgency of medical decision making	3.75	3.75
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	3.00	3.75
Outcome depends on the skill and judgment of physician	4.50	4.25
Estimated risk of malpractice suit with poor outcome	4.25	4.25

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.75	3.25
Intra-Service intensity/complexity	4.25	3.75
Post-Service intensity/complexity	3.25	3.75

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Why is this Code Being Presented to the RUC?
The family of percutaneous interventional codes was identified by the RUC 5-Year Review Identification Workgroup for higher than anticipated increase in volume.

What is the "big picture" overview of this multiple code procedure?
The family includes four possible treatment modalities (angioplasty, stenting, atherectomy, stenting plus atherectomy) that can be used in three arterial beds (iliac, femoropopliteal, tibial). This SoR represents the code for angioplasty in an additional tibial-peroneal vessel and describes the work involved in performing an angioplasty of a second (or third) vessel after angioplasty of the first tibial vessel.

The New Codes Bundle Selective Catheterization, Intervention and Radiological S&I
Currently, all percutaneous vascular interventions are reported with the component coding approach, meaning that separate codes are reported for selective catheterization, intervention, and radiological supervision and interpretation. In contrast, the new codes in this family BUNDLE these aspects of the service.

Why are there Primary Codes and Add-On Codes in this proposal?
The tibial arterial bed has four vessels (tibial-peroneal trunk, anterior tibial, posterior tibial, and peroneal). Most commonly only one of these three vessels would be treated, and a single primary code would be used to report that work. In the less common clinical situation in which more than one vessel requires treatment, the appropriate add-on code would be used (ie, Z17-Z20)

Pre-service Time
Patients who require interventional treatment at more than one site will obligatorily require an increment of additional pre-service evaluation work by the physician for completion of a thorough pre-procedural assessment. The physician needs to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, which order to proceed in, what approach to use, and what impact the second site will have on potential use of an embolic protection device. The median survey pre-time was 10 minutes. Our expert Consensus Panel reviewed the extra work that must be done, and the ultimate recommendation is 1 minute.

Post-service Time
There is a small but real amount of additional post-service work above and beyond that already provided for the primary procedure includes more time reviewing extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation to patient and family. More attention needs to be paid to the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion. The median survey immediate post time was 10 minutes. Our expert Consensus Panel reviewed the extra work that must be done, and the ultimate recommendation is 1 minute rather than 10.

How is Additional Tibial Atherectomy, PTA, and Stent Currently Reported and Valued?
Component coding is used currently to report this procedure. The primary procedure is assigned full RVU value while subsequent 0-, 10-, and 90-day global procedures receive a 50% multiple procedure payment reduction. XXX radiological supervision and interpretation codes are not subject to a multiple procedure payment reduction.

The procedure that will soon be reported with 37232 is currently reported with the existing tibial angioplasty code 35470 @ 8.62 RVUs with 50% multiple procedure = 4.31 reported with its radiological S&I code 75964 @ 0.36. Additionally, the catheterization of each additional tibial artery would be reported 36248 @ 1.01 RVUs or a total of 5.64 RVUs.

Thus, a common current coding scenario for additional vessel tibial PTA could result in the following RVUs:

Tibial angioplasty		4.31 (after multiple procedure payment reduction)
Tibial PTA S&I		0.36
Catheterization		1.01
Total	=	5.68 RVUs currently for an additional tibial PTA.

Thus, our current median survey recommendation of 5.00 work RVUs for new code 37232 would represent an 11% reduction compared to current component coding using 2010 RVUs.

Comparison with Key Reference Service
Key reference 34826 is analogous to the surveyed service. Intraservice time of the reference is less, but the work itself is similar to 37232 in that during an ongoing complex endovascular intervention (aortic endografting) an additional procedure is done with already existing catheters in place. Compared to placement of an aortic cuff, tibial intervention involves considerably more superselective catheter work (as opposed to nonselective placement of a stent-graft extension) with greater lengths of diseased vessel and longer catheters. Tibial intervention involve the complexity of multiple lesions treated with a greater possibility of distal embolization and/ or vascular occlusion. Thus, the additional work increment compared to the reference service is justified by time and intensity metrics.

IWPUT
IWPUT of 37232 at the median survey recommended RVW is 0.124. This value is typical for add-on ZZZ codes used in complex percutaneous intra-arterial work. This IWPUT also lies well within the range of the current proposal and existing IWPUT for vascular intervention including the reference service. For example:

Service	RUC Year	IWPUT
37232 Add'l Tibial PTA	**new**	**0.124**
33884 Thoracic stent-graft extension	2002	0.137
34826 Extension stent-graft extension	2002	0.137
61642 Intracranial PTA	2005	0.144

SERVICES REPORTED WITH MULTIPLE 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. Use 372X12 in conjunction with 372X8-372X11

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 35470, 75964 and 36248

How often do physicians 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 surgery How often? Commonly

Specialty radiology How often? Commonly

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. Unable to estimate National frequency.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 9,793
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached table for estimated Medicare frequency.

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 35685

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:37233 Tracking Number Z18 Specialty Society Recommended RVU: **6.50**

Global Period: ZZZ RUC Recommended RVU: **6.50**

CPT Descriptor: Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy (372X13 includes 372X12 when performed) (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old diabetic male presents with gangrene of the right 2nd and 3rd toes. Diagnostic studies reveal severe trifurcation (tibial/peroneal artery) disease. The posterior tibial artery is totally occluded. Both the peroneal and anterior tibial arteries have severe disease, with short segments of total occlusion in each vessel. Treatment of the second vessel will be by atherectomy. (Treatment of the initial vessel is separately coded.)

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

ercent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 91%

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? 67%

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: Patients who require interventional treatment at more than one site will obligatorily require an increment of additional pre-service evaluation work by the physician for completion of a thorough pre-procedural assessment. The physician needs to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, which order to proceed in, what approach to use, and what impact the second site will have on potential use of an embolic protection device.

Description of Intra-Service Work: This procedure is generally performed through the same access as that used for the base code procedure (372X9). A catheter and guidewire are manipulated into the diseased additional tibial/peroneal artery using fluoroscopic guidance. Roadmapping images are obtained for vessel sizing and to document anatomy. The area of stenosis/occlusion is crossed with a guidewire, crossing catheter, re-entry, or forceps device as previously outlined. It may e appropriate to place a distal embolic protection device, which may require pre-dilatation of a tight stenosis or area of occlusion. An atherectomy may be performed primarily or secondarily. Based on vessel measurements, an appropriate atherectomy device is chosen and is advanced into the diseased segment and positioned using fluoroscopic guidance and contrast injection. Multiple passes are made with the atherectomy device, physically removing plaque from the vessel. The atherectomy catheter may require periodic removal from the vessel to empty the collection chamber for plaque. It is

then introduced into the vessel again over the wire and the process is repeated until the desired amount of plaque has been removed. Atherectomy may be done in conjunction with balloon angioplasty, either in the same segment of the vessel or in separate segments of the vessel, depending on anatomy and pathology present. Imaging is performed after the atherectomy. If the lesion has been satisfactorily opened, angioplasty would not be performed at that level. If the lesion is incompletely opened, it could be treated further with additional atherectomy or with balloon angioplasty. An appropriately size angioplasty balloon catheter is advanced to the area of stenosis and is positioned using fluoroscopic guidance, and then is inflated to the appropriate pressure and time for opening of the lesion. The balloon is removed or pulled back over the wire, and follow-up images are obtained with contrast injection to determine if the stenosis has been adequately treated. Once a satisfactory result has been documented in the absence of extravasation or embolization, the embolic protection device is retrieved if used, the sheath is removed, and hemostasis obtained with manual compression, closure device, or surgical closure of the arteriotomy.

Description of Post-Service Work: Additional post-service work over and above that already provided for the primary procedure includes more time reviewing extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation to patient and family. More attention needs to be paid to the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Joseph Babb, MD; David Han, MD; Clifford Kavinsky, MD; Arthur Lee, MD; Geraldine McGinty, MD; Gerald Niedzwiecki, MD; Gary Seabrook, MD; Mathew Sideman, MD; Zeke Silva, MD; Gregory Thomas, MD; Sean Tutton, MD; Robert Vogelzang, MD; Robert Zwolak, MD				
Specialty(s):	Cardiology; Vascular Surgery; Radiology				
CPT Code:	37233				
Sample Size:	600	**Resp N:** 58	**Response:** 9.6 %		
Sample Type:	Random	**Additional Sample Information:** random and panel			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**3.00**	10.00	50.00
Survey RVW:	3.30	5.00	**6.50**	8.86	13.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	25.00	36.00	**60.00**	110.00	240.00

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: ZZZ Global Code

CPT Code:	37233	**Recommended Physician Work RVU: 6.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**1.00**	**0.00**	**1.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**1.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
34826	ZZZ	4.12	**RUC Time**

CPT Descriptor Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code 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
63295	ZZZ	5.25	**RUC Time**	31

CPT Descriptor 1 Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
22534	ZZZ	5.99	**RUC Time**	818

CPT Descriptor 2 Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (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: 5 **% of respondents:** 8.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 37233**	**Key Reference CPT Code: 34826**	**Source of Time RUC Time**
Median Pre-Service Time	1.00	0.00	
Median Intra-Service Time	60.00	30.00	
Median Immediate Post-service Time	1.00	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	**62.00**	**30.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.67	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	2.67
Urgency of medical decision making	3.67	3.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.67	3.00
Physical effort required	4.00	2.67
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.67	3.33
Outcome depends on the skill and judgment of physician	4.67	3.33
Estimated risk of malpractice suit with poor outcome	3.33	4.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	3.50
Intra-Service intensity/complexity	4.67	3.00
Post-Service intensity/complexity	3.50	3.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Why is this Code Being Presented to the RUC?
The family of percutaneous interventional codes was identified by the RUC 5-Year Review Identification Workgroup for higher than anticipated increase in volume.

What is the "big picture" overview of this multiple code procedure?
The family includes four possible treatment modalities (angioplasty, stenting, atherectomy, stenting plus atherectomy) that can be used in three arterial beds (iliac, femoropopliteal, tibial). This SoR represents the code for angioplasty in an additional tibial-peroneal vessel and describes the work involved in performing an angioplasty of a second (or third) vessel after angioplasty of the first tibial vessel.

The New Codes Bundle Selective Catheterization, Intervention and Radiological S&I
Currently, all percutaneous vascular interventions are reported with the component coding approach, meaning that separate codes are reported for selective catheterization, intervention, and radiological supervision and interpretation. In contrast, the new codes in this family BUNDLE these aspects of the service.

Why are there Primary Codes and Add-On Codes in this proposal?
The tibial arterial bed has four vessels (tibial-peroneal trunk, anterior tibial, posterior tibial, and peroneal). Most commonly only one of these three vessels would be treated, and a single primary code would be used to report that work. In the less common clinical situation in which more than one vessel requires treatment, the appropriate add-on code would be used (ie, Z17-Z20).

Pre-service Time
Patients who require interventional treatment at more than one site will obligatorily require an increment of additional pre-service evaluation work by the physician for completion of a thorough pre-procedural assessment. The physician needs to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, which order to proceed in, what approach to use, and what impact the second site will have on potential use of an embolic protection device. The median survey pre-time was 10 minutes. Our expert Consensus Panel reviewed the extra work that must be done, and the ultimate recommendation is 1 minute.

Post-service Time
There is a small but real amount of additional post-service work above and beyond that already provided for the primary procedure includes more time reviewing extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation to patient and family. More attention needs to be paid to the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion. The median survey immediate post time was 10 minutes. Our expert Consensus Panel reviewed the extra work that must be done, and the ultimate recommendation is 1 minute rather than 10.

How is Additional Tibial Atherectomy, PTA, and Stent Currently Reported and Valued?
Component coding is used currently to report this procedure. The primary procedure is assigned full RVU value while subsequent 0-, 10-, and 90-day global procedures receive a 50% multiple procedure payment reduction. XXX radiological supervision and interpretation codes are not subject to a multiple procedure payment reduction.

The procedure that will soon be reported with 37233 is currently reported with the existing tibial angioplasty and atherectomy codes 35470 @ 8.62 RVUs with 50% multiple procedure = 4.31 and 35495 tibial atherectomy @ 9.48 RVUs with 50% multiple procedure reduction = 4.74 reported with the PTA radiological S&I code 75964 @ 0.36 and additional peripheral atherectomy S&I code 75993 @ 0.36 Additionally, the catheterization of each additional tibial artery would be reported 36248 @ 1.01 RVUs or a total of 10.74 RVUs

Thus, a common current coding scenario for additional vessel tibial atherectomy would result in the following RVUs:

Tibial angioplasty	4.31 (after multiple procedure payment reduction)
Tibial PTA S&I	0.36
Catheterization	1.01
Tibial atherectomy	4.74
Tibial atherec S&I	0.36
Total =	10.78 RVUs currently for an additional tibial atherectomy.

Thus, our current median survey recommendation of 6.50 work RVUs for new code Z17 would represent a 40% reduction compared to current component coding using 2010 RVUs.

Comparison with Key Reference Service

Key reference 34826 is analogous to the surveyed service. Intraservice time of the reference is less, but the work itself is similar to 37233 in that during an ongoing complex endovascular intervention (aortic endografting) an additional procedure is done with already existing catheters in place. Compared to placement of an aortic cuff, tibial intervention involves considerably more superselective catheter work (as opposed to nonselective placement of a stent-graft extension) with greater lengths of diseased vessel and longer catheters. Tibial intervention involve the complexity of multiple lesions treated with a greater possibility of distal embolization and/ or vascular occlusion. Thus, the additional work increment compared to the reference service is justified by time and intensity metrics.

We understand that IWPUT is more varied in add-on codes, but we can more accurately compare the reference service and the new code by adding 30 minutes to the reference service and multiplying by IWPUT:

Reference service 34826 + 30 minutes of time to equalize times (x 0.108) = 3.24 RVWs,
4.12 + 3.24 = 7.36 RVWs which compares well with our recommended RVW of 6.50

IWPUT

IWPUT of 37233 at the median survey recommended RVW is 0.108. This value is typical for add-on ZZZ codes used in complex percutaneous intra-arterial work. This IWPUT also lies well within the range of the current proposal and existing IWPUT for vascular intervention including the reference service. For example:

Service	RUC Year	IWPUT
37233 Addl tib Atherec	**New**	**0.108**
34826 extension stent-graft extension	2002	0.137
33884 Thoracic stent-graft extension	2002	0.137
61642 Intracranial PTA	2005	0.144

SERVICES REPORTED WITH MULTIPLE 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. Use 372X13 in conjunction with 372X9-372X11

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 35470, 35495, 75964, 75993 36248

How often do physicians 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 surgery How often? Commonly

Specialty radiology How often? Commonly

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. Unable to estimate National frequency.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,524
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached table for estimated Medicare frequency.

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 35500

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:37234 Tracking Number Z19 Specialty Society Recommended RVU: **5.50**

Global Period: ZZZ RUC Recommended RVU: **5.50**

CPT Descriptor: Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old diabetic male presents with gangrene of the right 2nd and 3rd toes. Diagnostic studies reveal severe trifurcation disease. The anterior tibial artery is totally occluded. Both the peroneal and posterior tibial arteries have severe disease, with segments of total occlusion in each vessel, but reconstitution of each vessel in the distal calf. Treatment of the second vessel will be with stent. (Treatment of the initial vessel is separately coded.)

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

ercent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 91%

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? 68%

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: Patients who require interventional treatment at more than one site will obligatorily require an increment of additional pre-service evaluation work by the physician for completion of a thorough pre-procedural assessment. The physician needs to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, which order to proceed in, what approach to use, and what impact the second site will have on potential use of an embolic protection device.

Description of Intra-Service Work: This procedure could be performed through the same arteriotomy as was used for the base procedure 372X10. If performed from the same access, additional selective catheterization work is required to reach the lesion(s) to be treated in the additional trifurcation vessel. However, it could also be done from a separate access, in which case a suitable access vessel is cannulated either percutaneously or with open exposure of the vessel, a sheath placed . the arteriotomy, and a catheter and guidewire are manipulated into the artery using fluoroscopic guidance. Roadmapping images are obtained for vessel sizing and to document anatomy. The area(s) of stenosis/occlusion is crossed with a guidewire, crossing catheter, re-entry, or forceps device as previously outlined. If lesions are being treated at a bifurcation, tandem wires may be used to cross stenoses at the origins of each vessel. It may be appropriate to place a distal embolic protection device, which may require pre-dilatation of a tight stenosis or area of occlusion. An atherectomy may be

performed primarily or secondarily. An appropriately sized stent length, diameter, and material is selected and positioned at the treatment site using fluoroscopic guidance, and the stent is deployed. Additional angioplasty may be needed to achieve optimum caliber. The stent delivery catheter and/or balloon are removed or pulled back over the wire, and follow-up images are obtained with contrast injection to determine if the stenosis has been adequately treated. Multiple balloon inflations may be required, or additional balloons with larger or smaller diameters may be used. Once a satisfactory result has been documented in the absence of extravasation or embolization, the embolic protection device is retrieved if used, the sheath is removed, and hemostasis obtained with manual compression, closure device, or surgical closure of the arteriotomy.

Description of Post-Service Work: Additional post-service work over and above that already provided for the primary procedure includes more time reviewing extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation to patient and family. More attention needs to be paid to the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010		
Presenter(s):	Joseph Babb, MD; David Han, MD; Clifford Kavinsky, MD; Arthur Lee, MD; Geraldine McGinty, MD; Gerald Niedzwiecki, MD; Gary Seabrook, MD; Mathew Sideman, MD; Zeke Silva, MD; Gregory Thomas, MD; Sean Tutton, MD; Robert Vogelzang, MD; Robert Zwolak, MD		
Specialty(s):	Cardiology; Vascular Surgery; Radiology		
CPT Code:	37234		
Sample Size:	600	**Resp N:** 59	**Response:** 9.8 %
Sample Type:	Random	**Additional Sample Information:** random and panel	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	5.00	50.00
Survey RVW:	3.11	4.96	**5.50**	8.00	12.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	20.00	30.00	**60.00**	85.00	210.00

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: ZZZ Global Code

CPT Code:	37234	**Recommended Physician Work RVU: 5.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**1.00**	**0.00**	**1.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**1.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
34826	ZZZ	4.12	**RUC Time**

CPT Descriptor Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code 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
63295	ZZZ	5.25	**RUC Time**	31

CPT Descriptor 1 Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
22534	ZZZ	5.99	**RUC Time**	818

CPT Descriptor 2 Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (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: 6 **% of respondents:** 10.1 %

TIME ESTIMATES (Median)	**CPT Code: 37234**	**Key Reference CPT Code: 34826**	**Source of Time RUC Time**
Median Pre-Service Time	1.00	0.00	
Median Intra-Service Time	60.00	30.00	
Median Immediate Post-service Time	1.00	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	**62.00**	**30.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.67	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	3.67	3.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	3.00
Physical effort required	3.33	2.67
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.67	3.33
Outcome depends on the skill and judgment of physician	4.00	3.67
Estimated risk of malpractice suit with poor outcome	3.33	3.67

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	3.50
Intra-Service intensity/complexity	4.00	3.00
Post-Service intensity/complexity	3.50	3.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Why is this Code Being Presented to the RUC?
The family of percutaneous interventional codes was identified by the RUC 5-Year Review Identification Workgroup for higher than anticipated increase in volume.

What is the "big picture" overview of this multiple code procedure?
The family includes four possible treatment modalities (angioplasty, stenting, atherectomy, stenting plus atherectomy) that can be used in three arterial beds (iliac, femoropopliteal, tibial). This SoR represents the code for angioplasty in an additional tibial-peroneal vessel and describes the work involved in performing an angioplasty of a second (or third) vessel after angioplasty of the first tibial vessel.

The New Codes Bundle Selective Catheterization, Intervention and Radiological S&I
Currently, all percutaneous vascular interventions are reported with the component coding approach, meaning that separate codes are reported for selective catheterization, intervention, and radiological supervision and interpretation. In contrast, the new codes in this family BUNDLE these aspects of the service.

Why are there Primary Codes and Add-On Codes in this proposal?
The tibial arterial bed has four vessels (tibial-peroneal trunk, anterior tibial, posterior tibial, and peroneal). Most commonly only one of these three vessels would be treated, and a single primary code would be used to report that work. In the less common clinical situation in which more than one vessel requires treatment, the appropriate add-on code would be used (ie, Z17-Z20)

Pre-service Time
Patients who require interventional treatment at more than one site will obligatorily require an increment of additional pre-service evaluation work by the physician for completion of a thorough pre-procedural assessment. The physician needs to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, which order to proceed in, what approach to use, and what impact the second site will have on potential use of an embolic protection device. The median survey pre-time was 10 minutes. Our expert Consensus Panel reviewed the extra work that must be done, and the ultimate recommendation is 1 minute.

Post-service Time
There is a small but real amount of additional post-service work above and beyond that already provided for the primary procedure includes more time reviewing extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation to patient and family. More attention needs to be paid to the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion. The median survey immediate post time was 10 minutes. Our expert Consensus Panel reviewed the extra work that must be done, and the ultimate recommendation is 1 minute rather than 10.

How is Additional Tibial Atherectomy, PTA, and Stent Currently Reported and Valued?
Component coding is used currently to report this procedure. The primary procedure is assigned full RVU value while subsequent 0-, 10-, and 90-day global procedures receive a 50% multiple procedure payment reduction. XXX radiological supervision and interpretation codes are not subject to a multiple procedure payment reduction.

The procedure that will soon be reported with 37234 is currently reported with the existing tibial angioplasty and stent codes 35470 tibial PTA @ 8.62 RVUs with 50% multiple procedure = 4.31 and 37206 addl intravascular stent @ 4.12 RVUs reported with the PTA radiological S&I code 75960 @ 0.82. Additionally, the catheterization of each additional tibial artery would be reported 36248 @ 1.01 RVUs or a total of 10.58 RVUs

Thus, a common current coding scenario for additional vessel tibial stent could result in the following RVUs:

Tibial angioplasty		4.31 (after multiple procedure payment reduction)
Catheterization		1.01
ıddl Tibial stent		4.12
Tibial atherec S&I		0.82
Total	=	10.26 RVUs currently for an additional tibial stent.

Thus, our current median survey recommendation of 5.50 work RVUs for new code 37234 would represent a 48% reduction compared to current component coding using 2010 RVUs.

Comparison with Key Reference Service

Key reference 34826 is analogous to the surveyed service. Intraservice time of the reference is less, but the work itself is similar to 37234 in that during an ongoing complex endovascular intervention (aortic endografting) an additional procedure is done with already existing catheters in place. Compared to placement of an aortic cuff, tibial intervention involves considerably more superselective catheter work (as opposed to nonselective placement of a stent-graft extension) with greater lengths of diseased vessel and longer catheters. Tibial intervention involve the complexity of multiple lesions treated with a greater possibility of distal embolization and/ or vascular occlusion. Thus, the additional work increment compared to the reference service is justified by time and intensity metrics.

We understand that IWPUT is more varied in add-on codes, but we can more accurately compare the reference service and the new code by adding 30 minutes to the reference service and multiplying by IWPUT:

Reference service 34826 + 30 minutes of time to equalize times (x 0.092) = 2.76 RVWs,
4.12 + 2.76 = 6.88 RVWs which compares with our recommended RVW of 5.50

IWPUT

'WPUT of 37234 at the median survey recommended RVW is 0.091. This value is typical for add-on ZZZ codes used in ɔmplex percutaneous intra-arterial work. This IWPUT also lies well within the range of the current proposal and existing IWPUT for vascular intervention including the reference service. For example:

Service		RUC Year	IWPUT
34826 extension stent-graft extension		2002	0.137
61642 Intracranial PTA		2005	0.144
33884 Thoracic stent-graft extension		2002	0.137
37234 Addl tib Stent	**New**	**0.091**	

SERVICES REPORTED WITH MULTIPLE 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. Use 372X14 in conjunction with 372X10, 372X11

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 35470, 37206, 75960, 36248

How often do physicians 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 surgery How often? Commonly

Specialty radiology How often? Commonly

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. Unable to estimate National frequency.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,125
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached table for estimated Medicare frequency.

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 92998

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:37235 Tracking Number Z20 Specialty Society Recommended RVU: **7.80**

Global Period: ZZZ RUC Recommended RVU: **7.80**

CPT Descriptor: Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old diabetic male presents with gangrene of the right 2nd and 3rd toes. Diagnostic studies reveal severe trifurcation (tibial/peroneal artery) disease. The anterior tibial artery is totally occluded. Both the peroneal and posterior tibial arteries have severe disease, with segments of total occlusion in each vessel, but reconstitution of each vessel in the distal calf. Treatment of the second vessel will be with stent and atherectomy. (Treatment of the initial vessel is separately coded.)

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 89%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 69%

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: Patients who require interventional treatment at more than one site will obligatorily require an increment of additional pre-service evaluation work by the physician for completion of a thorough pre-procedural assessment. The physician needs to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, which order to proceed in, what approach to use, and what impact the second site will have on potential use of an embolic protection device.

Description of Intra-Service Work: This procedure is generally performed through the same access as that used for the base code procedure 372X11. Roadmapping images are obtained for vessel sizing and to document anatomy. The area of stenosis/occlusion is crossed with a guidewire, crossing catheter, re-entry, or forceps device as previously outlined. It may be appropriate to place a distal embolic protection device, which may require pre-dilatation of a tight stenosis or area of occlusion. An atherectomy may be performed primarily or secondarily. Based on vessel measurements, an appropriate atherectomy device is chosen and is advanced into the diseased segment and positioned using fluoroscopic guidance and contrast injection. Multiple passes are made with the atherectomy device, physically removing plaque from the vessel. It is then introduced into the vessel again over the wire and the process is repeated until the desired amount of plaque has been

removed. Atherectomy may be done in conjunction with balloon angioplasty, either in the same segment of the vessel or in separate segments of the vessel, depending on anatomy and pathology present. Imaging is performed after the atherectomy. In the event of suboptimal atherectomy and angioplasty, a stent placement may be required. Using fluoroscopic guidance and appropriate roadmapping, stent length, diameter, and properties are chosen. The stent is positioned across the intended treatment zone, and is deployed. The stent may be seated or fully opened with additional angioplasty. The stent delive system and balloon are removed or pulled back over the wire, and follow-up images are obtained with contrast injection to determine if the lesion has been adequately treated and to exclude dissection or extravasation. Once a satisfactory result has been documented in the absence of extravasation or embolization, the embolic protection device is retrieved if used, the sheath is removed, and hemostasis obtained with manual compression, closure device, or surgical closure of the arteriotomy.

Description of Post-Service Work: Additional post-service work over and above that already provided for the primary procedure includes more time reviewing extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation to patient and family. More attention needs to be paid to the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Joseph Babb, MD; David Han, MD; Clifford Kavinsky, MD; Arthur Lee, MD; Geraldine McGinty, MD; Gerald Niedzwiecki, MD; Gary Seabrook, MD; Mathew Sideman, MD; Zeke Silva, MD; Gregory Thomas, MD; Sean Tutton, MD; Robert Vogelzang, MD; Robert Zwolak, MD				
Specialty(s):	Cardiology; Vascular Surgery; Radiology				
CPT Code:	37235				
Sample Size:	600	**Resp N:** 57	**Response:** 9.5 %		
Sample Type:	Random	**Additional Sample Information:** random and panel			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	4.00	50.00
Survey RVW:	3.42	5.50	**7.80**	9.30	15.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	30.00	60.00	**80.00**	120.00	270.00

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: ZZZ Global Code

CPT Code:	37235	**Recommended Physician Work RVU: 7.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**1.00**	**0.00**	**1.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**80.00**		

Immediate Post Service-Time:	**1.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
34826	ZZZ	4.12	**RUC Time**

CPT Descriptor Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code 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
63295	ZZZ	5.25	**RUC Time**	31

CPT Descriptor 1 Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
22534	ZZZ	5.99	**RUC Time**	818

CPT Descriptor 2 Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (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: 6 **% of respondents:** 10.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 37235**	**Key Reference CPT Code: 34826**	**Source of Time RUC Time**
Median Pre-Service Time	1.00	0.00	
Median Intra-Service Time	80.00	30.00	
Median Immediate Post-service Time	1.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	

Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Total Time	**82.00**	**30.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	2.67
Urgency of medical decision making	4.00	3.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	5.00	3.00
Physical effort required	4.00	2.67
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	3.33
Outcome depends on the skill and judgment of physician	4.67	3.67
Estimated risk of malpractice suit with poor outcome	3.67	4.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.50	3.50
Intra-Service intensity/complexity	5.00	3.00
Post-Service intensity/complexity	3.50	3.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Why is this Code Being Presented to the RUC?
The family of percutaneous interventional codes was identified by the RUC 5-Year Review Identification Workgroup for higher than anticipated increase in volume.

What is the "big picture" overview of this multiple code procedure?
The family includes four possible treatment modalities (angioplasty, stenting, atherectomy, stenting plus atherectomy) that can be used in three arterial beds (iliac, femoropopliteal, tibial). This SoR represents the code for angioplasty in an additional tibial-peroneal vessel and describes the work involved in performing an angioplasty of a second (or third) vessel after angioplasty of the first tibial vessel.

The New Codes Bundle Selective Catheterization, Intervention and Radiological S&I
Currently, all percutaneous vascular interventions are reported with the component coding approach, meaning that separate codes are reported for selective catheterization, intervention, and radiological supervision and interpretation. In contrast, the new codes in this family BUNDLE these aspects of the service.

Why are there Primary Codes and Add-On Codes in this proposal?
The tibial arterial bed has four vessels (tibial-peroneal trunk, anterior tibial, posterior tibial, and peroneal). Most commonly only one of these three vessels would be treated, and a single primary code would be used to report that work. In the less common clinical situation in which more than one vessel requires treatment, the appropriate add-on code would be used (ie, Z17-Z20)

Pre-service Time
Patients who require interventional treatment at more than one site will obligatorily require an increment of additional pre-service evaluation work by the physician for completion of a thorough pre-procedural assessment. The physician needs to consider the additional site of treatment, size of necessary devices for the second site, availability of those devices, which order to proceed in, what approach to use, and what impact the second site will have on potential use of an embolic protection device. The median survey pre-time was 10 minutes. Our expert Consensus Panel reviewed the extra work that must be done, and the ultimate recommendation is 1 minute.

Post-service Time
There is a small but real amount of additional post-service work above and beyond that already provided for the primary procedure includes more time reviewing extra films and dictating extra procedural details in the interpretation. Patients with more than one treatment site require longer discussion and explanation to patient and family. More attention needs to be paid to the limb that has multiple treatment sites to ensure absence of embolization and adequacy of perfusion. The median survey immediate post time was 10 minutes. Our expert Consensus Panel reviewed the extra work that must be done, and the ultimate recommendation is 1 minute rather than 10.

How is Additional Tibial Atherectomy, PTA, and Stent Currently Reported and Valued?
Component coding is used currently to report this procedure. The primary procedure is assigned full RVU value while subsequent 0-, 10-, and 90-day global procedures receive a 50% multiple procedure payment reduction. XXX radiological supervision and interpretation codes are not subject to a multiple procedure payment reduction.

The procedure that will soon be reported with 37235 is currently reported with the existing tibial atherectomy and stent codes: 35470 tibial atherectomy @ 9.48 RVUs with 50% multiple procedure = 4.74 and the additional peripheral atherectomy S&I code 75993 @ 0.36 and 37206 addl intravascular stent @ 4.12 RVUs reported with the stent placement radiological S&I code 75960 @ 0.82. Additionally, the catheterization of each additional tibial artery would be reported 36248 @ 1.01 RVUs or a total of 11.05 RVUs

Thus, a common current coding scenario for additional vessel tibial atherectomy and stent could result in the following RVUs:

Tibial atherectomy		4.74 (after multiple procedure payment reduction)
Tibial atherec S&I		0.36
Catheterization		1.01
Addl Tibial stent		4.12
Stent S&I		0.82
Total	=	11.05 RVUs currently for an additional tibial atherectomy and stent.

Thus, our current median survey recommendation of 7.80 work RVUs for new code 37235 would represent a 29% reduction compared to current component coding using 2010 RVUs.

Comparison with Key Reference Service
Key reference 34826 is analogous to the surveyed service. Intraservice time of the reference is less, but the work itself is similar to 37235 in that during an ongoing complex endovascular intervention (aortic endografting) an additional procedure is done with already existing catheters in place. Compared to placement of an aortic cuff, tibial intervention involves considerably more superselective catheter work (as opposed to nonselective placement of a stent-graft extension) with greater lengths of diseased vessel and longer catheters. Tibial intervention involve the complexity of multiple lesions treated with a greater possibility of distal embolization and/ or vascular occlusion. Thus, the additional work increment compared to the reference service is justified by time and intensity metrics.

We understand that IWPUTs are more varied in add-on codes, but we can more accurately compare the reference service and the new code by adding 50 minutes to the reference service and multiplying by IWPUT:

Reference service 34826 + 50 minutes of time to equalize times (x 0.098) = 4.90 RVWs,
4.12 + 4.90 = 9.02 RVWs which compares with our recommended RVW of 7.80

IWPUT
IWPUT of 37235 at the median survey recommended RVW is 0.097. This value is typical for add-on ZZZ codes used in complex percutaneous intra-arterial work. This IWPUT also lies well within the range of the current proposal and existing IWPUT for vascular intervention including the reference service. For example:

Service	RUC Year	IWPUT
37235 Addl tib Stent + Atherec	**New**	**0.097**
33884 Thoracic stent-graft extension	2002	0.137
34826 extension stent-graft extension	2002	0.137
61642 Intracranial PTA	2005	0.144

SERVICES REPORTED WITH MULTIPLE 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. Use 372X15 in conjunction with 372X11

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 35470, 75993, 37206, 75960, 36248

How often do physicians 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 surgery How often? Commonly

Specialty radiology How often? Commonly

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. Unable to estimate National frequency.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,420
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Please refer to attached table for estimated Medicare frequency.

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 35683

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

CPT Code: 37220

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor: 37220 Revascularization, iliac artery, unilateral, initial vessel; with transluminal angioplasty

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 SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Schedule space and equipment in facility

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:
RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: 37220 - Revascularization, iliac artery, unilateral, initial vessel; with transluminal angioplasty

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:

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Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/obtain consent
- Follow-up phone calls & prescriptions

ANGIO TECH –

- Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD

Intra-Service Clinical Labor Activities:

RN/LPN/MTA –

- 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
- Clean room/equipment by physician staff
- Check dressings & wound/ home care instructions /coordinate office visits /prescriptions

RN –

- Sedate/apply anesthesia
- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician / conscious sedation
- Monitor pt. following service/check tubes, monitors, drains

ANGIO TECH –

- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician in performing procedure

- Image post-process

RADIOLOGIC TECH –

- Prepare imaging equipment
- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Patient data entry (imaging)
- Acquiring images throughout procedure

Post-Service Clinical Labor Activities:

RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

CPT Code: 37221

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor: 37221 Revascularization, iliac artery, unilateral, initial vessel; with transluminal stent placement(s)

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 SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Schedule space and equipment in facility

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:
RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

CPT Code: 37221

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: 37221- Revascularization, iliac artery, unilateral, initial vessel; with transluminal stent placement(s)

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:

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Pre-Service Clinical Labor Activities:

RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/obtain consent
- Follow-up phone calls & prescriptions

ANGIO TECH –

- Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD

Intra-Service Clinical Labor Activities:

RN/LPN/MTA –

- 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
- Clean room/equipment by physician staff
- Check dressings & wound/ home care instructions /coordinate office visits /prescriptions

RN –

- Sedate/apply anesthesia
- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician / conscious sedation
- Monitor pt. following service/check tubes, monitors, drains

ANGIO TECH –

- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician in performing procedure
- Image post-process

RADIOLOGIC TECH –

- Prepare imaging equipment
- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Patient data entry (imaging)

Acquiring images throughout procedure

Post-Service Clinical Labor Activities:

RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

CPT Code: 37222

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: 37222 Revascularization, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)

Global Period: ZZZ

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

RN/LPN/MTA –

- Prepare room, additional equipment and supplies
- Clean room/additional equipment by physician staff

ANGIO TECH –

- Assist physician in performing additional procedure
- Additional image post-process

RADIOLOGIC TECH –

- Acquiring additional images throughout procedure

RN –

- Assist physician / additional conscious sedation

Post-Service Clinical Labor Activities:

CPT Code: 37223

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: 37223 Revascularization, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s) (List separately in addition to code for primary procedure)

Global Period: ZZZ

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

RN/LPN/MTA –

- Prepare room, additional equipment and supplies
- Clean room/additional equipment by physician staff

ANGIO TECH –

- Assist physician in performing additional procedure
- Additional image post-process

RADIOLOGIC TECH –

- Acquiring additional images throughout procedure

RN –

- Assist physician / additional conscious sedation

Post-Service Clinical Labor Activities:

CPT Code: 37224

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor: 37224 Revascularization, femoral/popitieal artery(s), unilateral; with transluminal angioplasty

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 SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Schedule space and equipment in facility

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: 37224 - Revascularization, femoral/popliteal artery(s), unilateral; with transluminal angioplasty

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 SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/obtain consent
- Follow-up phone calls & prescriptions

ANGIO TECH –

- Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD

Intra-Service Clinical Labor Activities:

RN/LPN/MTA –

- 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
- Clean room/equipment by physician staff
- Check dressings & wound/ home care instructions /coordinate office visits /prescriptions

RN –

- Sedate/apply anesthesia
- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician / conscious sedation
- Monitor pt. following service/check tubes, monitors, drains

ANGIO TECH –

- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician in performing procedure

- Image post-process

RADIOLOGIC TECH –

- Prepare imaging equipment
- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Patient data entry (imaging)
- Acquiring images throughout procedure

Post-Service Clinical Labor Activities:

RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

CPT Code: 37225

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor: 37225 Revascularization, femoral/popitieal artery(s), unilateral; with atherectomy

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 SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Schedule space and equipment in facility

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: 37225 - Revascularization, femoral/popliteal artery(s), unilateral; with atherectomy

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 SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/obtain consent
- Follow-up phone calls & prescriptions

ANGIO TECH –

- Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD

Intra-Service Clinical Labor Activities:

RN/LPN/MTA –

- 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
- Clean room/equipment by physician staff
- Check dressings & wound/ home care instructions /coordinate office visits /prescriptions

RN –

- Sedate/apply anesthesia
- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician / conscious sedation
- Monitor pt. following service/check tubes, monitors, drains

ANGIO TECH –

- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician in performing procedure
- Image post-process

RADIOLOGIC TECH –

- Prepare imaging equipment
- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Patient data entry (imaging)

Acquiring images throughout procedure

Post-Service Clinical Labor Activities:

RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

CPT Code: 37226

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor: 37226 Revascularization, femoral/popitieal artery(s), unilateral; with transluminal stent placement (s)

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 SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Schedule space and equipment in facility

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

CPT Code: 37226

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: 37226- Revascularization, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s)

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 SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/obtain consent
- Follow-up phone calls & prescriptions

ANGIO TECH –

Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD

Intra-Service Clinical Labor Activities:

RN/LPN/MTA –

- 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
- Clean room/equipment by physician staff
- Check dressings & wound/ home care instructions /coordinate office visits /prescriptions

RN –

- Sedate/apply anesthesia
- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician / conscious sedation
- Monitor pt. following service/check tubes, monitors, drains

ANGIO TECH –

- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician in performing procedure
- Image post-process

RADIOLOGIC TECH –

- Prepare imaging equipment
- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Patient data entry (imaging)
- Acquiring images throughout procedure

Post-Service Clinical Labor Activities:

RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

CPT Code: 37227

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor: 37227 Revascularization, femoral/popitieal artery(s), unilateral; with transluminal stent placement (s) and atherectomy

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 SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Schedule space and equipment in facility

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

CPT Code: 37227

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: 37227- Revascularization, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy

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 SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/obtain consent
- Follow-up phone calls & prescriptions

ANGIO TECH –

- Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD

Intra-Service Clinical Labor Activities:

RN/LPN/MTA –

- 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
- Clean room/equipment by physician staff
- Check dressings & wound/ home care instructions /coordinate office visits /prescriptions

RN –

- Sedate/apply anesthesia
- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician / conscious sedation
- Monitor pt. following service/check tubes, monitors, drains

ANGIO TECH –

- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician in performing procedure
- Image post-process

RADIOLOGIC TECH –

- Prepare imaging equipment
- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Patient data entry (imaging)

Acquiring images throughout procedure

Post-Service Clinical Labor Activities:

RN/LPN/MTA –

Conduct phone calls/call in prescriptions

CPT Code: 37228

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor: 37228 Revascularization, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty

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:

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Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Schedule space and equipment in facility

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:
RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

CPT Code: 37228

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: 37228 Revascularization, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty

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 SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/obtain consent
- Follow-up phone calls & prescriptions

ANGIO TECH –

- Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD

Intra-Service Clinical Labor Activities:

RN/LPN/MTA –

- 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
- Clean room/equipment by physician staff
- Check dressings & wound/ home care instructions /coordinate office visits /prescriptions

RN –

- Sedate/apply anesthesia
- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician / conscious sedation
- Monitor pt. following service/check tubes, monitors, drains

ANGIO TECH –

- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician in performing procedure
- Image post-process

RADIOLOGIC TECH –

- Prepare imaging equipment
- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Patient data entry (imaging)
- Acquiring images throughout procedure

Post-Service Clinical Labor Activities:

RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

CPT Code: 37229

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor: 37229 Revascularization, tibial/peroneal artery, unilateral, initial vessel; with atherectomy

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 SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Schedule space and equipment in facility

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

CPT Code: 37229

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: 37229 - Revascularization, tibial/peroneal artery, unilateral, initial vessel; with atherectomy

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 SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/obtain consent
- Follow-up phone calls & prescriptions

ANGIO TECH –

- Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD

Intra-Service Clinical Labor Activities:

RN/LPN/MTA –

- 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
- Clean room/equipment by physician staff
- Check dressings & wound/ home care instructions /coordinate office visits /prescriptions

RN –

- Sedate/apply anesthesia
- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician / conscious sedation
- Monitor pt. following service/check tubes, monitors, drains

ANGIO TECH –

- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician in performing procedure
- Image post-process

RADIOLOGIC TECH –

- Prepare imaging equipment
- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Patient data entry (imaging)
- Acquiring images throughout procedure

Post-Service Clinical Labor Activities:

RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

CPT Code: 37230

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor: 37230 Revascularization, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement (s)

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 SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Schedule space and equipment in facility

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:
RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

CPT Code: 37230

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: 37230- Revascularization, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s)

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 SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/obtain consent
- Follow-up phone calls & prescriptions

ANGIO TECH –

- Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD

Intra-Service Clinical Labor Activities:

RN/LPN/MTA –

- 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
- Clean room/equipment by physician staff
- Check dressings & wound/ home care instructions /coordinate office visits /prescriptions

RN –

- Sedate/apply anesthesia
- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician / conscious sedation
- Monitor pt. following service/check tubes, monitors, drains

ANGIO TECH –

- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician in performing procedure
- Image post-process

RADIOLOGIC TECH –

- Prepare imaging equipment

- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Patient data entry (imaging)

Acquiring images throughout procedure

Post-Service Clinical Labor Activities:

RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

CPT Code: 37231

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor: 37231 Revascularization, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement (s) and atherectomy

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 SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Schedule space and equipment in facility

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:
RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: 37231- Revascularization, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy

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 SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

RN/LPN/MTA –

- Complete pre-service diagnostic & referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/obtain consent
- Follow-up phone calls & prescriptions

ANGIO TECH –

- Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD

Intra-Service Clinical Labor Activities:

RN/LPN/MTA –

- 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
- Clean room/equipment by physician staff
- Check dressings & wound/ home care instructions /coordinate office visits /prescriptions

RN –

- Sedate/apply anesthesia
- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician / conscious sedation
- Monitor pt. following service/check tubes, monitors, drains

ANGIO TECH –

- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Assist physician in performing procedure
- Image post-process

RADIOLOGIC TECH –

- Prepare imaging equipment

- Confirm orders, patient identity and mandatory time out prior to procedure initiation
- Patient data entry (imaging)
- Acquiring images throughout procedure

Post-Service Clinical Labor Activities:

RN/LPN/MTA –

- Conduct phone calls/call in prescriptions

CPT Code: 37232

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: 37232 Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)

Global Period: ZZZ

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

RN/LPN/MTA –

- Prepare room, additional equipment and supplies
- Clean room/additional equipment by physician staff

ANGIO TECH –

- Assist physician in performing additional procedure
- Additional image post-process

RADIOLOGIC TECH –

- Acquiring additional images throughout procedure

RN –

- Assist physician / additional conscious sedation

Post-Service Clinical Labor Activities:

CPT Code: 37233

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: 37233 Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy (List separately in addition to code for primary procedure)

Global Period: ZZZ

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

RN/LPN/MTA –

- Prepare room, additional equipment and supplies
- Clean room/additional equipment by physician staff

ANGIO TECH –

- Assist physician in performing additional procedure
- Additional image post-process

RADIOLOGIC TECH –

- Acquiring additional images throughout procedure

RN –

- Assist physician / additional conscious sedation

Post-Service Clinical Labor Activities:

CPT Code: 37234

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: 37234 Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) (List separately in addition to code for primary procedure)

Global Period: ZZZ

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

RN/LPN/MTA –

- Prepare room, additional equipment and supplies
- Clean room/additional equipment by physician staff

ANGIO TECH –

- Assist physician in performing additional procedure
- Additional image post-process

RADIOLOGIC TECH –

- Acquiring additional images throughout procedure

RN –

- Assist physician / additional conscious sedation

Post-Service Clinical Labor Activities:

CPT Code: 37235

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: 37235 Revascularization, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy (List separately in addition to code for primary procedure)

Global Period: ZZZ

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The SIR, ACR, SVS, ACC, SCAI convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. An expert panel was used to finalize recommendations with all geographical practice settings and all practice types represented.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

RN/LPN/MTA –

- Prepare room, additional equipment and supplies
- Clean room/additional equipment by physician staff

ANGIO TECH –

- Assist physician in performing additional procedure
- Additional image post-process

RADIOLOGIC TECH –

- Acquiring additional images throughout procedure

RN –

- Assist physician / additional conscious sedation

Post-Service Clinical Labor Activities:

	A	B	C	D		F	G	H	I	J	K	L	M	N	O
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**Z7**		**Z8**		**Z17**		**Z18**		**Z19**		**Z20**	
2				37222		37223		37232		37233		37234		37235	
3	**Meeting Date: April 2010**	CODE	Staff	Iliac PTA add'l vessel		Iliac stent add'l vessel		Tib/Per PTA add'l vessel		Tib/Per Atherectomy add'l vessel		Tib/Per Stent add'l vessel		Tib/Per Stent+Ather add'l vessel	
4	LOCATION			Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC
5	GLOBAL PERIOD			ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ
6	TOTAL CLINICAL LABOR TIME			122	0	137	0	122	0	182	0	182	0	242	0
7	TOTAL CLINICAL LABOR TIME RN/LPN/MTA	L037D	RN/LPN/MTA	10	0	11		10		15		15		20	
8	TOTAL CLINICAL LABOR TIME RN	L051A	RN	40		45		40		60		60		80	
9	TOTAL CLINICAL LABOR TIME ANGIO TECH	L041A	Angio Tech	42		47		42		62		62		82	
10	TOTAL CLINICAL LABOR TIME RAD TECH	L041B	Rad Tech	30		34		30		45		45		60	
11	TOTAL PRE-SERV CLINICAL LABOR TIME			0	0	0	0	0	0	0	0	0	0	0	0
12	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			122	0	137	0	122	0	182	0	182	0	242	0
13	SERVICE PERIOD RN/LPN/MTA	L037D	RN/LPN/MTA	10		11		10		15		15		20	
14	SERVICE PERIOD RN	L051A	RN	40		45		40		60		60		80	
15	SERVICE PERIOD ANGIO TECH	L041A	Angio Tech	42		47		42		62		62		82	
16	SERVICE PERIOD RAD TECH	L041B	Rad Tech	30		34		30		45		45		60	
17	TOTAL POST-SERV CLINICAL LABOR TIME			0	0	0	0	0	0	0	0	0	0	0	0
18	**PRE-SERVICE**														
19	**Start: Following visit when decision for surgery or procedure made**														
26	**End: When patient enters office/facility for surgery/procedure**														
27	**SERVICE PERIOD**														
28	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**														
29	Obtain vital signs														
30	Provide pre-service education/obtain consent														
31	Prepare room, equipment, supplies														
32	Prepare imaging equipment														
33	Setup scope (non facility setting only)														
34	Prepare and position patient/ monitor patient/ set up IV														
35	Sedate/apply anesthesia														
36	**Intra-service**														
37	Patient data entry (imaging)														
38	Assist physician in performing procedure	L041A	Angio Tech	40		45		40		60		60		80	
39	Assist physician / conscious sedation	L051A	RN	40		45		40		60		60		80	
40	Assist with fluoroscopy/image acquisition - circulating throughout the procedure [SPLIT: SEE ROWS 42 & 43]														
41	One staff typically assists with fluoroscopy/image acquisition circulating throughout the procedure for 100% of physcian intra-service time PERC pre-facilitation recommends split staff type: 75% RT for imaging task and 25% RN/LPN/MTA blend for circulating task														
42	**Assisting with fluoroscopy/image acquisition (75%)**	L041B	Rad Tech	30		34		30		45		45		60	
43	**circulating throughout the procedure (25%)**	L038B	RN/LPN/MTA	10		11		10		15		15		20	
44	Image post-process	L041A	Angio Tech	2		2		2		2		2		2	
45	Monitor pt following service/check tubes, monitors, drains														
46	**Clean room/equipment by physician staff**														
47	Clean Scope														
48	Clean Surgical Instrument Package														
49	Complete diagnostic forms, lab & X-ray requisitions														
50	Review/read X-ray, lab, and pathology reports														
51	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions														
52	Discharge day management														
53	Other Clinical Activity (please specify)														
54	**End: Patient leaves office**														
55	**POST-SERVICE Period**														
56	**Start: Patient leaves office/facility**														
68	**End: with last office visit before end of global period**														

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
2				37222		37223		37232		37233		37234		37235	
3	**Meeting Date: April 2010**	CODE	Staff	Iliac PTA add'l vessel		Iliac stent add'l vessel		Tib/Per PTA add'l vessel		Tib/Per Atherectomy add'l vessel		Tib/Per Stent add'l vessel		Tib/Per Stent+Ather add'l vessel	
4	**LOCATION**			Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC
69	**MEDICAL SUPPLIES**	Code	Unit												
83	Equipment	Code													
84	room, angiography	EL011		40		45		40		60		60		80	
85	IV infusion pump	EQ032		40		45		40		60		60		80	
86	contrast medie warmer	EQ088		40		45		40		60		60		80	
87	film alternator (motorized film viewbox)	ER029		40		45		40		60		60		80	
88	printer, dye sublimation (photo, color)	ED031		2		2		2		2		2		2	
89	stretcher	EF018		40		45		40		60		60		80	
90	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		40		45		40		60		60		80	

	A	B	C	D	E	F	G	H		J	K	L	M	N	O	P	Q	R	S	T	U	V		X	Y
1	AMA/Specialty Society RVS Update Committee Recommendation					Z5		Z6		Z9		Z10		Z11		Z12		Z13		Z14		Z15		Z16	
2				36147		37220		37221		37224		37225		37226		37227		37228		37229		37230		37231	
3	Meeting Date: April 2010	CODE	Staff	Introduction of needle and/or catheter, arteriovenous shunt		Iliac PTA		Iliac stent		Fem/Pop PTA		Fem/Pop Atherectomy		Fem/Pop Stent		Fem/Pop Stent+Ather		Tib/Per PTA		Tib/Per Atherectomy		Tib/Per Stent		Tib/Per Stent+Ather	
4	LOCATION			Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC
5	GLOBAL PERIOD			XXX	XXX	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000
6	TOTAL CLINICAL LABOR TIME			174	6	298	9	388	9	358	9	472	9	388	9	493	9	388	9	478	9	478	9	523	9
7	TOTAL CLINICAL LABOR TIME BY STAFF TYPE			174	6	298	9	388	9	358	9	472	9	388	9	493	9	388	9	478	9	478	9	523	9
8	TOTAL CLINICAL LABOR TIME RN/LPN/MTA	L037D	RN/LPN/MTA	33	6	45	9	53	9	50	9	60	9	53	9	61	9	53	9	60	9	60	9	64	9
9	TOTAL CLINICAL LABOR TIME RN	L051A	RN	47		122		152		142		180		152		187		152		182		182		197	
10	TOTAL CLINICAL LABOR TIME ANGIO TECH	L041A	Angio Tech	45		71		101		91		129		101		136		101		131		131		146	
11	TOTAL CLINICAL LABOR TIME RAD TECH	L041B	Rad Tech	49		60		83		75		104		83		109		83		105		105		116	
12	TOTAL PRE-SERV CLINICAL LABOR TIME			15	3	15	6	15	6	15	6	15	6	15	6	15	6	15	6	15	6	15	6	15	6
13	PRE-SERVICE RN/LPN/MTA	L037D	RN/LPN/MTA	9	3	9	6	9	6	9	6	9	6	9	6	9	6	9	6	9	6	9	6	9	6
14	PRE-SERVICE ANGIO TECH	L041A	Angio Tech	6		6		6		6		6		6		6		6		6		6		6	
15	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			156		280		370		340		454		370		475		370		460		460		505	
16	SERVICE PERIOD RN/LPN/MTA	L037D	RN/LPN/MTA	21		33		41		38		48		41		49		41		48		48		52	
17	SERVICE PERIOD RN	L051A	RN	47		122		152		142		180		152		187		152		182		182		197	
18	SERVICE PERIOD ANGIO TECH	L041A	Angio Tech	39		65		95		85		123		95		130		95		125		125		140	
19	SERVICE PERIOD RAD TECH	L041B	Rad Tech	49		60		83		75		104		83		109		83		105		105		116	
20	TOTAL POST-SERV CLINICAL LABOR TIME			3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
21	POST-SERVICE PERIOD RN/LPN/MTA	L037D	RN/LPN/MTA	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
22	PRE-SERVICE																								
23	Start: Following visit when decision for surgery or procedure made																								
24	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3		3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
25	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3		3		3		3		3		3		3		3		3		3		3	
26	Schedule space and equipment in facility	L037D	RN/LPN/MTA				3		3		3		3		3		3		3		3		3		3
27	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			0		0		0		0		0		0		0		0		0		0	
28	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3	3		3		3		3		3		3		3		3		3		3	
29	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		6		6		6		6		6		6		6		6		6	
30	End When patient enters office/facility for surgery/procedure																								
31	SERVICE PERIOD																								
32	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure																								
33	Review Charts	L037D	RN/LPN/MTA	2		2		2		2		2		2		2		2		2		2		2	
34	Greet patient and provide gowning	L037D	RN/LPN/MTA	3		3		3		3		3		3		3		3		3		3		3	
35	Obtain vital signs	L037D	RN/LPN/MTA	5		5		5		5		5		5		5		5		5		5		5	
36	Other Clinical Activity (please specify)Pre-procedure doppler check in addition to initial vitals	LO37D	RN/LPN/MTA	3																					
37	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		5		5		5		5		5		5		5		5		5		5	
38	Prepare room, equipment, supplies	L037D	RN/LPN/MTA			0		0		0		0		0		0		0		0		0		0	
39	Prepare room, IMAGING equipment, supplies	L041B	Rad Tech	7		7		7		7		7		7		7		7		7		7		7	
40	Setup scope (non facility setting only)																								
41	Prepare and position patient/ monitor patient/ set up IV	L041B	Rad Tech	5		5		5		5		5		5		5		5		5		5		5	
42	Sedate/apply anesthesia	L051A	RN	2		2		2		2		2		2		2		2		2		2		2	
43	Other Clinical Activity (please specify): TIME OUT - ANGIO TECH - Confirm orders, patient identity and mandatory time out prior to procedure initiation	L041A	Angio Tech			Referred to Subcommittee																			
44	Other Clinical Activity (please specify): TIME OUT - RAD TECH - Confirm orders, patient identity and mandatory time out prior to procedure initiation	L041B	Rad Tech			Referred to Subcommittee																			
45	Other Clinical Activity (please specify): TIME OUT RN - Confirm orders, patient identity and mandatory time out prior to procedure initiation	L051A	RN			Referred to Subcommittee																			
46	Intra-service																								
47	Patient data entry (imaging)	L041B	Rad Tech			0		0		0		0		0		0		0		0		0		0	
48	Assist physician in performing procedure	L041A	Angio Tech	34		60		90		80		118		90		125		90		120		120		135	
49	Assist physician / conscious sedation	L051A	RN	45		60		90		80		118		90		125		90		120		120		135	
50	Assist with fluoroscopy/image acquisition - circulating throughout the procedure [SPLIT. SEE ROWS 52 & 53]	L041B	Rad Tech	34																					

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y
1	AMA/Specialty Society RVS Update Committee Recommendation					Z5		Z6		Z9		Z10		Z11		Z12		Z13		Z14		Z15		Z16	
2				36147		37220		37221		37224		37225		37226		37227		37228		37229		37230		37231	
3	Meeting Date: April 2010	CODE	Staff	Introduction of needle and/or catheter, arteriovenous shunt		Iliac PTA		Iliac stent		Fem/Pop PTA		Fem/Pop Atherectomy		Fem/Pop Stent		Fem/Pop Stent+Ather		Tib/Per PTA		Tib/Per Atherectomy		Tib/Per Stent		Tib/Per Stent+Ather	
4	LOCATION			Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC
51	One staff typically assists with fluoroscopy/image acquisition circulating throughout the procedure for 100% of physician intra-service time PERC pre-facilitation recommends split staff type· 75% RT for imaging task and 25% RN/LPN/MTA blend for circulating task																								
52	Assisting with fluoroscopy/image acquisition (75%)	L041B	Rad Tech			45		68		60		89		68		94		68		90		90		101	
53	circulating throughout the procedure (25%)	L038B	RN/LPN/MTA			15		23		20		30		23		31		23		30		30		34	
54	Image post-process	L041A	Angio Tech	5		5		5		5		5		5		5		5		5		5		5	
55	Monitor pt following service/check tubes, monitors, drains, PUNCTURE SITE [Standard of 4 hours post procedure monitoring for arterial access cases involving conscious sedation. 15 min RN per hour = 60 min]	L051A	RN			60		60		60		60		60		60		60		60		60		60	
56	Clean room/IMAGING equipment by physician staff	L041B	Rad Tech	3		3		3		3		3		3		3		3		3		3		3	
57	Clean room/equipment by physician staff	L038B	RN/LPN/MTA			0		0		0		0		0		0		0		0		0		0	
62	Check dressings & wound/ home care instructions /coordinate OVs Rx	L037D	RN/LPN/MTA	3		3		3		3		3		3		3		3		3		3		3	
63	Discharge day management																								
64	End: Patient leaves office																								
65	POST-SERVICE Period																								
66	Start: Patient leaves office/facility																								
67	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
78	End with last office visit before end of global period																								

	A	B	C	D	E	F	G	H		J	K	L	M	N	O	P	Q	R	S	T	U	V		X	Y
1	AMA/Specialty Society RVS Update Committee Recommendation					Z5		Z6		Z9		Z10		Z11		Z12		Z13		Z14		Z15		Z16	
2				36147		37220		37221		37224		37225		37226		37227		37228		37229		37230		37231	
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4	LOCATION			Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC
79	MEDICAL SUPPLIES	Code	Unit																						
80	pack, minimum multi-specialty visit	SA048	pack			1		1		1		1		1		1		1		1		1		1	
81	pack, conscious sedation	SA044	pack			1		1		1		1		1		1		1		1		1		1	
82	gown, surgical, sterile	SB028	item			2		2		2		2		2		2		2		2		2		2	
83	gloves, sterile	SB024	pair			2		2		2		2		2		2		2		2		2		2	
84	mask, surgical, with face shield	SB034	item			4		4		4		4		4		4		4		4		4		4	
85	cap, surgical	SB001	item			4		4		4		4		4		4		4		4		4		4	
86	shoe covers, surgical	SB039	pair			4		4		4		4		4		4		4		4		4		4	
87	tray, shave prep	SA067	tray			1		1		1		1		1		1		1		1		1		1	
88	underpad 2ftx3ft (Chux)	SB044	item			1		1		1		1		1		1		1		1		1		1	
89	drape, sterile, femoral	SB009	item			1		1		1		1		1		1		1		1		1		1	
90	drape-towel, sterile 18inx26in	SB019	item			4		4		4		4		4		4		4		4		4		4	
91	Betadine	SJ041	ml			60		60		60		70		70		70		70		70		70		70	
92	applicator, sponge-tipped	SG009	item			4		4		4		4		4		4		4		4		4		4	
93	lidocaine 1%-2% inj (Xylocaine)	SH047	ml			10		10		10		10		10		10		10		10		10		10	
94	syringe 10-12 ml	SC051	item			4		4		4		4		4		4		4		4		4		4	
95	syringe, 20 cc	SC053	item			4		4		4		4		4		4		4		4		4		4	
96	sodium chloride 0 9% flush syringe	SH065	item			2		2		2		2		2		2		2		2		2		2	
97	closed flush system, angiography	SC010	item			1		1		1		1		1		1		1		1		1		1	
98	blade, surgical (Bard-Parker)	SF007	item			1		1		1		1		1		1		1		1		1		1	
99	steri-strip (6 strip pou)	SG074	item			1		1		1		1		1		1		1		1		1		1	
100	guidewire bowl w-lid, sterile	SD171	item			2		2		2		2		2		2		2		2		2		2	
101	gauze, sterile 4in x 4in	SG055	item			2		2		2		2		2		2		2		2		2		2	
102	dressing 3 X 4 wound care telfa	SG035	item			2		2		2		2		2		2		2		2		2		2	
103	drape, sterile, c-arm, fluoro	SB008	item			1		1		1		1		1		1		1		1		1		1	
104	disinfectant, surface (Envirocide, Sanizide)	SM013	oz			1		1		1		1		1		1		1		1		1		1	
105	biohazard bag	SM004	item			2		2		2		2		2		2		2		2		2		2	
106	kit, AccuStick II Introducer System with RO Marker	SA071	kit			1		1		1		1		1		1		1		1		1		1	
107	Sterile Radio-opaque ruler (le Maitre, documentation available)	NEW	item			1		1		1		1		1		1		1		1		1		1	
108	SHEATHS																								
109	vascular sheath	SD136	item			1		1		1		1		1		1		1		1		1		1	
110	introducer sheath, Ansel (45 cm 6 Fr Ansel (Cook product number G29982, KCFW-6 0-18138-34-RG-ALI-HC))	NEW	item			1		1		1		1		1		1		1		1		1		1	
111	Sheath Shuttle (Cook)	NEW	item															1		1		1		1	
112	GUIDEWIRES																								
113	guidewire, (Bentson)	SD172	item			1		1		1		1		1		1		1		1		1		1	
114	guidewire, STIFF	SD090	item			1		1		1		1		1		1		1		1		1		1	
115	guidewire, hydrophilic (Glidewire)	SD089	item			1		1		1		1		1		1		1		1		1		1	
116	guidewire, Amplatz wire 260 cm	NEW	item							1		1		1		1		1		1		1		1	
117	guidewire, low profile (SpartaCore)	SD173	item									1				1		2		3		3		3	
118	CATHETERS																								
119	catheter, angiographic, pig-tail	SC008	item			1		1		1		1		1		1		1		1		1		1	
120	catheter (Glide)	SD147	item			1		1		1		1		1		1		1		1		1		1	
121	catheter (SIM2F1)	SD148	item			1		1		1		1		1		1		1		1		1		1	
122	catheter microcatheter selective	SD154	item															1		1		1		1	
123	Quick Cross Catheter (Sprectranetics, documentation available)	NEW	item			1		1		1		1		1		1		1		1		1		1	
124	ANGIOPLASTY BALLOONS																								
125	catheter, balloon, low profile PTA	SD151	item			2		1		3		4		3		4		2		2		2		2	
126	ATHERECTOMY DEVICES																								
127	atherectomy device (Spectronetics laser or Fox Hollow)	NEW	kit									1				1				1				1	
128	STENTS																								
129	stent, vascular, deployment system, Cordis SMART [6-12/14 mm]	NA	kit					1																	
130	stent, self expanding 2-5 mm XPERT (Abbott)	NEW	item																			2		2	
131	covered stent (VIABAHN, Gore)	NEW	item											3		3									
132	OTHER DEVICES																								
133	Reentry device (Frontier, Outback, Pioneer)	NEW	item									1		1		1				1		1		1	
134	Embolic Protection Device Spider FX (EV3, documentation available)	NEW	item									1		1		1		1		1		1		1	
135	suture device for vessel closure (Perclose A-T)	SD207	item			1		1		1		1		1		1		1		1		1		1	
136	IMAGING SUPPLIES																								

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3	Meeting Date: April 2010	CODE	Staff	Introduction of needle and/or catheter, arteriovenous shunt		Iliac PTA		Iliac stent		Fem/Pop PTA		Fem/Pop Atherectomy		Fem/Pop Stent		Fem/Pop Stent+Ather		Tib/Per PTA		Tib/Per Atherectomy		Tib/Per Stent		Tib/Per Stent+Ather	
4	LOCATION			Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC	Non-Fac	FAC
137	x-ray ID card (flashcard)	SK093	item			1		1		1		1		1		1		1		1		1		1	
138	film, x-ray 14inx17in	SK034	item			6		6		2		2		2		2		6		6		6		6	
139	x-ray envelope	SK091	item			1		1		1		1		1		1		1		1		1		1	
140	x-ray developer solution	SK089	oz			6		6		6		6		6		6		6		6		6		6	
141	x-ray fixer solution	SK092	oz			6		6		6		6		6		6		6		6		6		6	
142	PHARMACEUTICALS																								
143	heparin 1,000 units-ml inj	SH039	ml			5		10		5		10		10		10		5		10		10		10	
144	protamine sulfate 10 mg/ml (5ml uou vial)	NEW	item			1		1		1		1		1		1		1		1		1		1	
145	nitroglycerin injection USP 5 mg/mL (10ml uou vial)	NEW	item			1		1		1		1		1		1		1		1		1		1	
146	Equipment	Code																							
147	room, angiography	EL011		54		90		120		110		148		120		155		120		150		150		165	
148	IV infusion pump	EQ032		128		153		183		173		211		183		218		183		213		213		228	
149	contrast media warmer	EQ088				90		120		110		148		120		155		120		150		150		165	
150	film alternator (motorized film viewbox)	ER029		4		90		120		110		148		120		155		120		150		150		165	
151	printer, laser, paper	ED032		4																					
152	printer, dye sublimation (photo, color)	ED031				5		5		5		5		5		5		5		5		5		5	
153	stretcher chair	EF019		72																					
154	stretcher	EF018				153		183		173		211		183		218		183		213		213		228	
155	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		128		153		183		173		211		183		218		183		213		213		228	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from Five-Year Review – CMS Fastest Growing Screen

October 2009

Percutaneous Cholecystostomy

In October 2008, CPT code 47490 *Percutaneous Cholecystostomy* (2010 Work RVU = 8.13, 090 day global) was requested to be reviewed by CMS following identification by the RUC as potentially misvalued. This service was identified by the RUC's Five-Year Review Identification Workgroup's fastest growing screen and Harvard-valued. In February 2009, the Workgroup recommended the service descriptor be revised by the CPT Editorial Panel to include the imaging guidance by any method to account for the typical procedure, and change the global period to 000, as the number of hospital visits varies widely among physicians who are managing the patient's post-operative care.

975

The CPT Editorial Panel in May 2009, combined the percutaneous cholecystomy service with radiographic guidance of CPT code 75989 *Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation* (2010 Work RVU = 1.19) as they are billed together on the same day approximately 95% of the time. CMS assigned CPT code 47490 a global period of 010, rather than 000.

The American College of Radiology and the Society of Interventional Radiology conducted a survey with nearly 70 respondents. The RUC first reviewed the physician time data collected by the specialty. The RUC agreed that the positioning time for pre-procedure imaging was indeed more than the standard pre-time package for a facility based difficult patient/straightforward procedure with sedation of one minute, and therefore an additional 9 minutes was typical for the task. A total pre-service time of 48 minutes was accepted. In addition, the median and 25th percentile survey results indicated 30 minutes of intra-service physician time was necessary for this service.

The RUC reviewed three other 010 day global services with similar intensities and complexities, inter and post-operatively; 49440 *Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (Work RVU = 4.18, intra-service time = 38 minutes, one post-operative hospital visit), 49441 *Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (Work RVU = 4.77, intra-service time = 45 minutes, one post-operative hospital visit), and 49442 *Insertion of cecostomy or other colonic tube,*

percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report (Work RVU = 4.00, intra-service time = 30 minutes, one post-operative hospital visit). The RUC also concurred that interventional radiologists are part of the care team for these critically ill patients, and provide appropriate hospital care. Although the survey results indicated that these physicians typically provided 3 post-operative hospital visits, the RUC agreed that two were typical.

The RUC also reviewed similar services such as the specialty's key reference service 49041 *Drainage of subdiaphragmatic or subphrenic abscess; percutaneous* (Work RVU = 3.99, 000 day global, intra-service time = 60 minutes) and multi-specialty points of comparison code 49320 *Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (Work RVU = 5.14, 010 day global, intra-service time of 45 minutes, includes one post-operative hospital visit) in considering the appropriate work value.

The RUC agreed that the services provided with CPT code 47490 are very similar to those of CPT code 49442 with an extra hospital visit. The RUC therefore agreed on a relative work value of 4.76 for code 47490 by taking the work value of 49442 of 4.00 and adding the work value an additional hospital 99231 visit of 0.76.

976

CPT Code	Work Value
49442	4.00
99231	0.76
New value of 47490	**4.76**

The RUC recommends a relative work value of 4.76 for CPT code 47490.

Practice Expense: The RUC concurred that the typical service of code 47490 is performed only in the facility setting and therefore no direct practice expense inputs are recommended at this time.

Practice Liability Insurance Crosswalk: The RUC agreed that the appropriate physician practice liability insurance crosswalk is the base code, 49442, used in the physician work building block methodology.

Work Neutrality
The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
E 47480		Cholecystotomy or cholecystostomy, open, with exploration, drainage, or removal of calculus (separate procedure) (For percutaneous cholecystostomy, use 47490)	090	13.25 (No Change)
▲47490	A1	Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation (Do not report 47490 in conjunction with 47505, 74305, 75989, 76942, 77002, 77012, 77021)	010	4.76

977

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:47490 Tracking Number A1 Specialty Society Recommended RVU: **4.76**
Global Period: 010 RUC Recommended RVU: **4.76**

CPT Descriptor: Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72 year old female is admitted to the Coronary Care Unit following open heart surgery, and 2 days later develops respiratory failure, fever and elevated white blood count. A CT scan (separately reported) documents acute acalculous cholecystitis, and she is referred for percutaneous cholecystostomy.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 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) 1% , Admitted (more than 24 hours) 99%

Percent of survey respondents 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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 85%

Is moderate sedation inherent to this procedure in the office setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the office setting? 16%

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:

- Review patient history, medications and prior imaging.
- Review laboratory findings.
- Discuss procedure with patient and family.
- Obtain informed consent.
- Confirm room and equipment set-up, including availability of imaging equipment to be utilized.
- Appropriate supplies such as catheters, needles and wires are selected.
- Perform and/or review preliminary ultrasound examination, fluoroscopic and/or CT images (not separately reported) of the target area to choose an appropriate location on the skin for the incision.
- Monitor patient positioning and draping, and assist with positioning as needed.
- Scrub and gown.

Description of Intra-Service Work:

- Administer conscious sedation.
- The skin is prepped, draped, and local anesthesia applied.

- A tiny skin incision is made, and the gallbladder is punctured using direct ultrasound guidance with a long 21-gauge needle; alternatively, the needle is placed with CT guidance with confirmatory images obtained following needle placement.
- A wire is advanced into the gallbladder using fluoroscopic guidance, and the needle is removed.

The tract is dilated and an 8-French drainage catheter is advanced into the gallbladder, positioned appropriately, and secured in position.

- A sample of the bile may be sent for culture and sensitivity.
- Contrast is injected to confirm the position of the catheter and assess for bile leakage around the catheter; alternatively CT images post procedure are obtained and reviewed to confirm the location of the catheter in the gallbladder.
- The catheter is placed to gravity drainage, and a sterile dressing is applied.
- Images to be saved and stored in the patient's permanent record are selected by the physician.

Description of Post-Service Work:

- Procedure note is dictated and reviewed.
- Sign procedure forms, indicating pre and post-op diagnoses, procedure performed.
- Write orders for subsequent catheter management, including charting of output, frequency of flushes, and care for entry site.
- Discuss procedure outcome with patient, family, and other physicians.
- Follow patient during hospital admission to assess response to therapy, assure appropriate antibiotic coverage when cultures are available, check catheter entry site for leak or other complication, and monitor output.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2009				
Presenter(s):	Geraldine McGinty, MD, Ezequiel Silva, MD, Sean Tutton, MD, Gerald Niedzwiecki, MD, Robert Vogelzang, MD				
Specialty(s):	ACR and SIR				
CPT Code:	47490				
Sample Size:	333	**Resp N:**	67	**Response:** 20.1 %	
Sample Type:	Panel	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	5.00	**10.00**	20.00	44.00
Survey RVW:	3.37	3.93	**5.22**	8.58	20.00
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	20.00	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):	**60.00**	99231x **3.00** 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:	47490	**Recommended Physician Work RVU: 4.76**		
		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:		**10.00**	**1.00**	**9.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**40.00**	99231x **2.00** 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
49041	000	3.99	**RUC Time**

CPT Descriptor Drainage of subdiaphragmatic or subphrenic abscess; percutaneous

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
49320	010	5.09	**RUC Time**	8,890

CPT Descriptor 1 Laparoscopy, abdomen, peritoneum, and omentum, 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

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: 19 **% of respondents:** 28.3 **%**

TIME ESTIMATES (Median)	CPT Code: 47490	Key Reference CPT Code: 49041	Source of Time RUC Time
Median Pre-Service Time	48.00	38.00	
Median Intra-Service Time	30.00	60.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0 00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**133.00**	**128.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.73	2.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.93	2.71
Urgency of medical decision making	3.40	2.71
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.53	3.07
Physical effort required	2.93	2.79
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.53	3.07
Outcome depends on the skill and judgment of physician	3.53	3.29
Estimated risk of malpractice suit with poor outcome	3.27	2.93

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.07	2.64
Intra-Service intensity/complexity	3.60	3.14
Post-Service intensity/complexity	2.71	2.43

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

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 49041 with work value of 3.99. The median survey data for 47490 shows work value of 5.22 with 60 min pre, 30 min intra and 15 min post. This

new code, as mandated by the five-year review process, is bundled and includes imaging guidance, previously reported separately as 75989. 75989 is also reported with our reference service and has a work value of 1.19 and total time of 23 minutes. Thus, when considering 49041 plus 75989, the total value of 5.18 is comparable to our survey results.

The reference service has a 0 day global while the new code has a 10 day global. The vast majority of our surveys indicate that their post-procedure care includes multiple 99231 (average of 5 visits) with many of those indicating the higher level service 99232. We are recommending 3 separate 99231 follow-up hospital visits. We are not recommending discharge day management or office visits since physicians performing this service are typically consultants and follow-up office visits would be expected outside the 10 day global. We recognize that our respondents included pre-service time greater than the standard RUC package applicable to this service. We recommend reducing the pre-service evaluation time from 40 to 33 minutes and the scrub, dress and wait time from 10 to 5 minutes in accordance with package 2B. We recommend, however, maintaining the median positioning time of 10 minutes to accommodate the additional time required for pre-procedure imaging.

The societies were initially recommending the median work value for 47490 of 5.22 with the median physician time adjusted to the pre-service rationale above with times of 48 min pre, 30 min intra and 15 minutes post. They were also recommending 3 separate 99231 post procedure visits. These recommendations yield an IWPUT of 0.053, which is slightly higher than our reference service reflective of the higher intensity indicated on 11 out of 11 of the complexity measures. Further, our MPC comparison code of 49320 with a 10 day global and times of 40 min pre, 45 min intra and 30 min post compares favorably, particularly given the acute nature of these patients and the greater degree of pre and post procedure care necessary.

After speaking with RUC members the specialty changed their recommendation to 4.76 through the following building block methodology, where code 49442 was used as a base code:

CPT Code	Work Value
49442	4.00
99231	0.76
New value of 47490	**4.76**

The RUC and the specialty's agreed with the building block methodology relative work value of code 47490 of 4.76 was appropriate.
The RUC recommends a relative work value of 4.76 for CPT code 47490.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 47490 and 75989

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Interventional Radiology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 31197
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 47490 and 75989 in a one year period is estimated to be 31197.

Specialty Diagnostic Radiology Frequency 26178 Percentage 83.91 %

Specialty Interventional Radiology Frequency 5019 Percentage 16.08 %

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? 5,513
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 code 47490 was billed approximately 5,513 (4475 for DR,858 for IR, and 180 others). For code 75989,(total = 60,789). We estimate that the number of times code 75989 was billed with 47490 was approximately 5,238 (4,251 for DR, 815 for IR, and 172 other) and these will no longer be reported.

Specialty Diagnostic Radiology Frequency 4475 Percentage 81.17 %

Specialty Interventional Radiology Frequency 858 Percentage 15.56 %

Specialty Other Frequency 180 Percentage 3.26 %

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? (ie. simil. work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 49442

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, 010, or 090 Day Global Periods
Non Facility and Facility Direct Inputs

CPT Long Descriptor:
Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation.

Global Period:_10_

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 recommends no direct practice expense inputs for the percutaneous cholecystotomy code, 47490.

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:

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five-Year Review – Site-of-Service Anomaly

April 2010

Intraperitoneal Catheter Codes

CPT code 49421 *Insertion of tunneled intraperitoneal or catheter for dialysis; open* was identified through a site-of-service anomaly screen by the RUC Five-Year Review Identification Workgroup. Subsequent to that identification, CMS added the related code 49420 *Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary* for review and agreed that both codes should have a global period of 000 because of the wide variation in post-procedure work. At the April 2008 RUC meeting, the specialty requested that both codes 49420 and 49421 be referred to the CPT Editorial Panel for investigation and clarification of the history of the codes and the inclusion of the terms temporary and permanent. The belief was that the original intention of the descriptors had changed over time because of the addition of new catheter codes - for approach, diagnosis, and treatment.

686

The CPT Editorial Panel agreed to delete code 49420 based on the specialty presentation that there may be inadvertent miscoding because the descriptor is vague with respect to catheter placement for drainage. Additionally, temporary "rigid" cannulas are no longer manufactured or utilized. CPT code 49421 was revised to clearly indicate it was an open procedure. A new CPT code 49418 *Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation; percutaneous* was approved to describe percutaneous procedures.

49421
Before reviewing the specialty's survey and physician time data, the RUC discussed the original valuation of this Harvard valued service and how its previous valuation as a 090 day global service relates to the current valuation with a 000 day global. When the Harvard study was conducted, surveyees were asked to provide estimated minutes for pre, intra and post service physician time. As there were no standard evaluation and management visits when this code was originally valued, visits were arbitrarily assigned based on the surveyees' time estimates. The RUC agreed that compelling evidence is not necessary and the assigned post-operative visits should not be backed out of the current valuation, due to the change in global periods, because they were not part of the original Harvard work, but were assigned by a CMS contractor for the purpose of calculating practice expense RVUs.

The RUC reviewed the survey results from 34 general surgeons for code 49421 and agreed with the specialty that the survey respondents accurately captured the physician work and time necessary to complete this procedure. The RUC agreed that pre-service time package 3 (Facility: Straightforward Patient/Difficult Procedure) was accurate with the deletion of 5 minutes for scrub, dress and wait time to accurately reflect the time required to perform the pre-service activities (pre-service time= 46 minutes). The RUC agreed that the survey median intra-service time of 45 minutes and post service time of 20 minutes accurately reflects the physician time required to perform this service.

The RUC compared code 49421 to the Key Reference Service 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (Work RVU= 4.17 and intra-service time= 30 minutes). The RUC agreed that although these procedures are similar, code 49421 requires more intra-service time and should be valued higher than 32550. Also, the RUC reviewed the survey intensity and complexity measures which indicated code 49421 requires greater intensity and complexity to perform as compared to the reference code 32550. Finally, the RUC reviewed MPC code 45380 *Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple* (Work RVU= 4.43 and intra-service time= 51.5 minutes) in relation to the surveyed code and agreed that 49421 should be valued lower than 45380 to reflect less intra-service time. This comparison further substantiated the specialty's median survey physician work RVU of 4.21 and ensures reflects appropriate relativity. **The RUC recommends 4.21 work RVUs for 49421.**

066

49418

The RUC reviewed the survey results from 31 radiologists for code 49418 and agreed with the specialties that the survey respondents accurately captured the physician time necessary to compete this procedure, but overestimated the physician work involved. The RUC agreed that pre-service time package 2b (Facility: Difficult Patient/Straightforward Procedure (with sedation/anesthesia) was accurate with the addition of 5 minutes to the positioning time to accommodate ultrasound which is necessary to identify the location for initial access. The survey median intra-service time of 40 minutes and post service time of 20 minutes also accurately accounted for the physician time involved in performing the procedure.

The RUC compared code 49418 to the Key Reference Service code *36558 Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older* (Work RVU= 4.84 and total time= 116 minutes). The RUC agreed that the reference service, which has a 010 day global period and more total work, should be valued higher than 49418. In addition, the RUC reviewed 49418 in comparison to a 000-day global code 31571 *Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope or telescope* (Work RVU= 4.26, intra-service time= 40 minutes and total time= 129 minutes). The RUC agreed that these services should be valued similarly. Given that the physician time and work for the open procedure (49421) is very similar to the percutaneous procedure 49418, the RUC agreed that a value of 4.21 work RVUs, lower than the survey's

25th percentile and the same as the recommendation for 49421, maintains appropriate relativity. **The RUC recommends 4.21 work RVUs for 49418.**

Moderate Sedation:
The RUC, after reviewing the survey data for procedure 49418, noted that moderate sedation is inherent. **Therefore, the RUC recommends that CPT code 49418 be added to Appendix G in the CPT 2011 Book and the moderate sedation symbol "◎" be added to 49418.**

Practice Expense
The RUC reviewed the direct practice expense inputs and modified the medical supplies and equipment to reflect what is used to perform the typical service.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
E 49324		Laparoscopy, surgical; with insertion of tunneled intraperitoneal ~~cannula or~~ catheter~~, permanent~~ *(For subcutaneous extension of intraperitoneal catheter with remote chest exit site, use 49435 in conjunction with 49324)* (For open insertion of tunneled ~~permanent~~ intraperitoneal ~~cannula or~~ catheter, see 49421)	010	6.32 (No Change)
Abdomen, Peritoneum, and Omentum **Introduction, Revision, Removal**				
E 49419		Insertion of tunneled intraperitoneal ~~cannula or~~ catheter, with subcutaneous port ~~reservoir, permanent open~~ (ie, totally implantable) (For removal, use 49422)	090	7.08 (No Change)

991

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
D 49420		~~Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary~~ (49420 has been deleted. To report open placement of a tunneled catheter for dialysis, use 49421. To report open or percutaneous peritoneal drainage, see 49060, 49061, 49080, 49081, as appropriate. To report percutaneous insertion of tunneled catheter, use 49418)	000	N/A
●49418	CC1	Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation; percutaneous	000	4.21
▲49421	CC2	Insertion of tunneled intraperitoneal ~~cannula or~~ catheter for drainage or dialysis; ~~permanent~~ open (For laparoscopic insertion of tunneled ~~permanent~~ intraperitoneal ~~cannula or~~ catheter, use 49324) (For subcutaneous extension of intraperitoneal catheter with remote chest exit site, use 49435 in conjunction with 49421)	~~090~~ 000	4.21
E 49422		Removal of tunneled ~~permanent~~ intraperitoneal ~~cannula or~~ catheter (For removal of a non-tunneled ~~temporary cannula/~~ catheter, use appropriate E/M code)	010	6.29 (No Change)

992

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
Medicine **Dialysis** **Miscellaneous Dialysis Procedures** (For laparoscopic insertion of tunneled intraperitoneal catheter, use 49324. For percutaneous insertion of tunneled intraperitoneal catheter, use 49418. For open insertion of tunneled intraperitoneal ~~cannula or~~ catheter, use ~~49420,~~ 49421) *(For prolonged physician attendance, see 99354-99360)*				

993

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:49418 Tracking Number CC1 Specialty Society Recommended RVU: **5.0**

Global Period: 000 RUC Recommended RVU: **4.21**

CPT Descriptor: Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation; percutaneous

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old female with end-stage renal disease due to diabetic nephropathy requires initiation of dialysis therapy. She is a candidate for peritoneal dialysis and undergoes percutaneous placement of a peritoneal dialysis catheter.

Percentage of Survey Respondents who found Vignette to be Typical: 52%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 97%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 42%

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:

- Review patient history, medications and prior imaging.
- Review laboratory findings.
- Discuss procedure with patient and family.
- Obtain informed consent.
- Confirm room and equipment set-up, including availability of imaging equipment to be utilized.
- Appropriate supplies such as catheters, needles and wires are selected.
- Perform and/or review preliminary ultrasound examination, fluoroscopic and/or CT images (not separately reported) of the target area to choose an appropriate location on the skin for the incision.
- Monitor patient positioning and draping, and assist with positioning as needed.
- Scrub and gown.

Description of Intra-Service Work:

- Administer conscious sedation.

- The skin is prepped, draped, and local anesthesia applied.
- Ultrasound interrogation of the peritoneal cavity is performed to identify free flowing or loculated ascitic fluid. A suitable site remote from bowel or other visceral organs is chosen.
- A tiny skin incision is made, and the peritoneal space is punctured using direct ultrasound guidance with a long 21-auge needle.
- A wire is advanced into the peritoneal space using fluoroscopic guidance, and the needle is removed.
- Using fluoroscopic guidance, a guide wire is maneuvered toward the pelvis or other unobstructed site.
- The tract is sequentially dilated with appropriate-sized dilators.
- A peel-away sheath is placed through the tract.
- A skin exit site for the catheter is chosen.
- Local anesthesia is used in the subcutaneous track between the access and exit sites. A small incision is made at the exit site, sufficiently large to accommodate the catheter.
- A cuffed dialysis catheter is advanced through the exit site, advanced through the subcutaneous tunnel and introduced into the peritoneum through the peel-away sheath.
- Fluoroscopic guidance is used to guide the catheter into satisfactory position.
- The peel-away sheath is removed.
- The incisions are closed with suture and sterile dressing is applied.
- Images to be saved and stored in the patient's permanent record are selected by the physician.

Description of Post-Service Work:

- Procedure note is dictated and reviewed.
- Sign procedure forms, indicating pre and post-op diagnoses, procedure performed.
- Discuss procedure outcome with patient, family and other physicians.
- Provide education to the patient regarding proper use of the catheter for subsequent ascites removal.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010					
Presenter(s):	Geraldine McGinty, MD, Ezequiel Silva, MD, Sean Tutton, MD, Robert Vogelzang, MD, Gerald Niedzwiecki, MD					
Specialty(s):	American College of Radiology and Society of Interventional Radiology					
CPT Code:	49418					
Sample Size:	267	**Resp N:**	31	**Response:** 11.6 %		
Sample Type:	Panel	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	5.00	**10.00**	15.00	100.00
Survey RVW:	3.20	5.00	**5.50**	7.00	15.00
Pre-Service Evaluation Time:			**40.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	20.00	30.00	**40.00**	60.00	75.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
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:	49418	**Recommended Physician Work RVU: 5.00**		
		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:		**6.00**	**1.00**	**5.00**
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
36558	010	4.84	**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
52276	000	4.99	**RUC Time**	12,142

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
2550	000	4.17	**RUC Time**

CPT Descriptor Insertion of indwelling tunneled pleural catheter with cuff

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 67.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 49418**	**Key Reference CPT Code: 36558**	**Source of Time RUC Time**
Median Pre-Service Time	44.00	36.00	
Median Intra-Service Time	40.00	30.00	
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	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**104.00**	**81.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.71	2.24
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.81	2.38
Urgency of medical decision making	2.33	2.19
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.10	2.81
Physical effort required	2.90	2.67
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.95	2.75
Outcome depends on the skill and judgment of physician	3.29	3.10
Estimated risk of malpractice suit with poor outcome	3.00	2.76

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.71	2.29
Intra-Service intensity/complexity	3.29	2.86
Post-Service intensity/complexity	2.43	2.24

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 ACR and SIR convened a panel that included a number of physicians familiar with this service to review the RUC survey data. We are recommending the 25th percentile work RVU of 5.0 and the median intra-service time of 40 minutes. We are recommending pre-service package 2b, to which we are adding 5 minutes of

positioning time to accommodate ultrasound which is necessary to identify the location for initial access. This ultrasound guidance (76937, 10 minutes of intra time) is included in this new code. For the post-service time we are recommending our 75%tile value of 30 minutes to reflect the increased amount of education that these patients and their families require for these highly specialized catheters which these patients must manage on their own at home. This education must be performed after recovery from sedation. The panel felt that our survey participants may have considered this education part of the pre-service period. We have elected to allocate that time to the post-service period since we believe education should take place with the catheter already in place for demonstration purposes. This further validates the 75%tile for post-procedure time.

Our panel felt that this service is also quite comparable to 32550 (Insertion of indwelling tunneled pleural catheter with cuff) with work value of 4.17 and time of 40 pre, 30 intra and 20 post. The type of catheter and technique between these 2 procedures is comparable. The increased time for the new code 49418 is due to the abdominal catheters requiring additional care to avoid a larger number of organs and the greater variability inherent to ascites compared to pleural fluid. Our recommended value is also appropriate when compared to the most commonly chosen reference service 36558 (Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older) with work value of 4.84 and time of 36 pre, 30 intra and 15 post. 36558 has a 10 day global period and when the E/M visits are removed from it, the value is 3.72 with 30 minutes intra-service time. The IWPUT for 32550, 36558 are .101and .091, respectively. The IWPUT for the new code 49418 is lower at .085, but still reflective of the work involved.

Our recommended value is also comparable to MPC code 52276 (Cystourethroscopy with direct vision internal urethrotomy) with work RVU of 4.99 and time of 30 pre, 35 intra and 30 post and IWPUT of .104.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49421 and 49420

How often do physicians 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 How often?

Estimate the number of times this service might be provided nationally in a one-year period? 19371
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 494XX in a one year period is estimated to be 19,371.

Specialty Radiology Frequency 1937 Percentage 9.99 %

Specialty Interventional Radiology Frequency 581 Percentage 2.99 %

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? 1,975
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The specialty estimates that 10% of the utilization for 49421 will be transitioned to this new code. Also 25% of the utilization of 49420 will be transitioned to this new code when it is deleted.

Specialty Radiology Frequency 197 Percentage 9.97 %

Specialty Interventional Radiology Frequency 60 Percentage 3.03 %

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? (ie. similar work RVU, and specialty) 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:49421 Tracking Number CC2 Specialty Society Recommended RVU: **4.21**

Global Period: 000 RUC Recommended RVU: **4.21**

CPT Descriptor: Insertion of tunneled intraperitoneal catheter for drainage or dialysis; open

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year old female with end-stage renal disease due to diabetic nephropathy requires initiation of dialysis therapy. The patient has a previous surgical history of cesarean section and open cholecystectomy. She is referred for placement of a peritoneal dialysis catheter and an open approach is selected.

Percentage of Survey Respondents who found Vignette to be Typical: 71%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 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

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Description of Pre-Service Work: Select and order the appropriate antibiotic(s) and confirm timing and administration. Reexamine patient to make sure that physical findings have not changed and update H&P. Review results of preadmission testing. Meet with patient and family to review planned procedure and post-operative management. Mark site and side of proposed skin incision and catheter exit site and confirm with patient. Review and obtain informed consent, including witness. Review length and type of anesthesia with anesthesiologist. Verify that all required instruments and supplies are available. Monitor/assist with positioning of patient. Indicate areas of skin to be prepped and draped. Scrub and gown. Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work: An incision in made in the anterior abdominal wall. Peritoneal access is confirmed and space for visualization of intra-abdominal structures is achieved. Exploration is performed to identify a clear space to which the peritoneal dialysis catheter will be directed. A sleeve or port conduit is inserted through the same or different abdominal wall incision to provide a channel for insertion of the peritoneal dialysis catheter. After insertion of the traperitoneal catheter segment, the cuffed portion of the catheter is secured to peritoneum and/or fascia. The extraperitoneal portion is tunneled subcutaneously from the abdominal wall insertion location to a separate skin exit-site. Flow function of the catheter is tested. Surgical wounds are repaired and dressings applied.

Description of Post-Service Work: Apply sterile dressings. Discuss postoperative recovery care with anesthesia and nursing staff. Write brief operative note. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Discuss procedure and outcome with family in waiting area. Answer patient and family questions. Write orders for follow-up, post-discharge labs, x-rays. Home restrictions (i.e., diet, activity, bathing) are discussed with the patient, family members and discharging nurse. The patient is discharged when she has recovered from anesthesia. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS				
Specialty(s):	general surgery				
CPT Code:	49421				
Sample Size:	200	**Resp N:**	34	**Response:** 17.0 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**3.00**	5.00	12.00
Survey RVW:	2.50	4.00	**4.21**	4.50	5.50
Pre-Service Evaluation Time:			**35.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	30.00	40.00	**45.00**	59.00	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:	**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: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	49421	**Recommended Physician Work RVU: 4.21**		
		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:		**10.00**	**15.00**	**-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:	**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
32550	000	4.17	**RUC Time**

CPT Descriptor Insertion of indwelling tunneled pleural catheter with cuff

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
45378	000	3.69	**RUC Time**	915,402

CPT Descriptor 1 Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
45380	000	4.43	**RUC Time**	801,741

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: 15 **% of respondents:** 44.1 %

TIME ESTIMATES (Median)	**CPT Code: 49421**	**Key Reference CPT Code:** 32550	**Source of Time** RUC Time
Median Pre-Service Time	46.00	30.00	
Median Intra-Service Time	45.00	30.00	
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	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**111.00**	**75.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.93	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.67	2.53
Urgency of medical decision making	2.40	2.20
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.47	2.93
Physical effort required	2.93	2.67
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.40	2.33
Outcome depends on the skill and judgment of physician	2.93	2.80
Estimated risk of malpractice suit with poor outcome	2.60	2.60

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.80	2.53
Intra-Service intensity/complexity	3.27	2.87
Post-Service intensity/complexity	2.33	2.47

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT code 49421 was identified through a site-of-service anomaly screen by the RUC Five-Year Review Identification Workgroup. Subsequent to that identification, CMS added code 49420 for review and agreed that both codes should have a global period of 000-days. At the April 2008 RUC meeting, the American College of Surgeons requested that

codes 49420 and 49421 be referred to the CPT Editorial Panel for investigation and clarification of the history of the codes and the inclusion of the terms temporary and permanent. We believe the original intention of these descriptors has changed over time because of the addition of new catheter codes - for approach, diagnosis, and treatment.

The College presented information to the CPT Editorial Panel to support our belief that the original intention of 49421 - supported by the Harvard review – was for open placement of a catheter for dialysis. The Panel accepted the recommendation to delete code 49420 and revise 49421 for that specific approach and use.

We recognize that the global period for 49421 has changed from 90-days to 0-days and the Harvard data associated with this code includes post-op visits. The current RVW for 49421 is 5.90, with an IWPUT of 0.031. While some may contend that the new value should simply reflect subtraction of the RVWs associated with the visits, we would argue that Harvard did not assign visits (number or level) during it's study, and that the assignment of visits by a CMS contractor came much later. The Harvard work to develop an RVW for 49421 did not include adding the exact RVWs for post-op visits, so it stands to reason that the RVWs for visits cannot simply be subtracted for a change in the global period. Instead, the RVW for the code needs to be compared on a relative scale to codes with a similar global period.

The American College of Surgeons conducted a RUC survey and received 34 responses. A consensus panel of general surgeons reviewed the survey data and agree that the median intra-operative time of 45 minutes is an accurate reflection of the time to perform this procedure. This is slightly more than the intra-time from the Harvard study. The consensus panel also believes that the key reference code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* requires comparable total work. We recommend the survey median RVW of 4.21 (IWPUT = 0.064) for revised code 49421. This RVW is almost identical to 32550, which is a very similar procedure.

In support of our recommendation, we reviewed two MPC codes with a 0-day global period that are familiar to general surgeons and that have slightly less and greater RVWs – 45378 (3.69) and 45380 (4.43). The recommendation of the median RVW of 4.21 falls between the RVWs for these two MPC codes. The intra-time and total time also fall between these two MPC codes.

Pre-time package 3 is selected as typical, with a reduction to the package positioning time match the survey median 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) 49421 and 49420

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
f the recommendation is from multiple specialties, please provide information for each specialty.

Specialty 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? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. not able to estimate national frequency

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? 9,801
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The specialty estimates that 90% of the utilization for this current code will be transitioned. Also, 75% of the utilization for the deleted code 49420 will be transitioned to this code.

Specialty general surgery Frequency 6000 Percentage 61.21 %

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? (ie. similar work RVU, and specialty) 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
Facility Direct Inputs

CPT Long Descriptor:
Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation; percutaneous

Global Period:000

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The ACR and SIR convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescriptions

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation; percutaneous

Global Period: 000

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The ACR and SIR convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information

Intra-Service Clinical Labor Activities:

- Greet patient, provide gowning, ensure appropriate medical records are available
- Obtain vital signs
- Provide pre-service education/ obtain consent
- Prepare room, equipment and supplies
- Prepare and position patient/ monitor patient/ set up IV
- Sedate/ apply anesthesia
- Monitor patient- conscious sedation
- Assist physician in performing procedure
- Assist physician with fluoroscopy during procedure
- Assist physician with image acquisition
- Monitor patient following service/ check tubes, monitors, drains
- Clean room/equipment by physician staff
- Clean surgical instrument package
- Complete diagnostic forms, lab and x-ray requisitions
- Check dressing and wound/home care instructions/ coordinate office visits/prescriptions
- Process films, hang films and review study with interpreting MD prior to patient discharge

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

AMA Specialty Recommendation

	A	B	C	D	E	F	G	H
1	**AMA/Specialty Society RVS Update Committee Recommendation**		**32550 (32019)**		**75989**		**49418**	
2		**CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE**	**Insertion of indwelling tunneled plerual catheter with cuff** **Approved PE Inputs**		**Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation** **Approved PE Inputs**		**Insertion of tunneled intraperitoneal catheter, complete procedure**	
3	**LOCATION**		**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**		0	0	xxx	xxx	0	0
5	**TOTAL CLINICAL LABOR TIME**		106.0	23 0	50.0	0.0	242.0	23 0
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**		5.0	20.0	6 0	0.0	11.0	20.0
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**		98 0	0.0	44.0	0.0	228.0	0.0
8	**TOTAL POST-SERV CLINICAL LABOR TIME**		3 0	3 0	0.0	0.0	3.0	3.0
9	**PRE-SERVICE**							
10	**Start: Following visit when decision for surgery or procedure made**							
11	Complete pre-service diagnostic & referral forms	RN/LPN/MTA	5	5			5	5
12	Coordinate pre-surgery services	RN/LPN/MTA						
13	Schedule space and equipment in facility	RT		5				5
14	Provide pre-service education/obtain consent	RN/LPN/MTA		7				7
15	Follow-up phone calls & prescriptions	RN/LPN/MTA		3				3
16	Other Clinical Activity (please specify)							
17	*- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information*	RT			6		6	
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	RT	2					
23	Greet patient, provide gowning, ensure appropriate medical records are available	RN/LPN/MTA	3				3	
24	Obtain vital signs	RN/LPN/MTA	5				5	
25	Provide pre-service education/obtain consent	RN/LPN/MTA	7		1		7	
26	Prepare room, equipment, supplies	RT	2		1		3	
27	Setup scope (non facility setting only)							
28	Prepare and position patient/ monitor patient/ set up IV	RT	2		1		3	
29	Sedate/apply anesthesia	RN	2				2	

1013

	A	B	TAB 11	D	E	F	G	H
1	**AMA/Specialty Society RVS Update Committee Recommendation**		**32550 (32019)**		**75989**		**49418**	
2		**CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE**	**Insertion of indwelling tunneled plerual catheter with cuff** **Approved PE Inputs**		**Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation** **Approved PE Inputs**		**Insertion of tunneled intraperitoneal catheter, complete procedure**	
3	**LOCATION**		**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
30	**Intra-service**							
31	**Monitor patient -- conscious sedation**	RN	30		18		40	
32	Assist physician in performing procedure	RT	20		18		40	
33	Assist physician with fluoroscopy during procedure	RT					30	
34	Assist physician with image acquisition	RN/LPN/MTA					10	
35	**Post-Service**							
36	Monitor pt. following service/check tubes, monitors, drains	RN	15				60	
37	Clean room/equipment by physician staff	RT	3		3		6	
38	Clean Scope							
39	Clean Surgical Instrument Package	RT					10	
40	Complete diagnostic forms, lab & X-ray requisitions	RT	2				2	
41	Review/read X-ray, lab, and pathology reports							
42	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	RN/LPN/MTA	5				5	
43	Discharge day management 99238 --12 minutes 99239 --15 minutes							
44	Other Clinical Activity (please specify)							
45	*- Process films, hang films and review study with interpreting MD prior to patient discharge*	RT			2		2	
46	**End: Patient leaves office**							
47	**POST-SERVICE Period**							
48	**Start: Patient leaves office/facility**							
49	Conduct phone calls/call in prescriptions	RN/LPN/MTA	3	3			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								
59	*Total Office Visit Time*		0	0				
60	Other Activity (please specify)							
61	**End: with last office visit before end of global period**							

1014

AMA Specialty Recommendation

	A	B	C	D	E	F	G	H
1	**AMA/Specialty Society RVS Update Committee Recommendation**		**32550 (32019)**		**75989**		**49418**	
2		**CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE**	**Insertion of indwelling tunneled plerual catheter with cuff** **Approved PE Inputs**		**Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation** **Approved PE Inputs**		**Insertion of tunneled intraperitoneal catheter, complete procedure**	
3	**LOCATION**		**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
62	**MEDICAL SUPPLIES**							
63	PEAC multispecialty supply package	SA048	1				1	
64	Conscious Sedation Pack	SA044	1				1	
65	Chux	SB044	2				2	
66	Mask with face shield	SB034	2				3	
67	Sterile gloves	SB024	1				2	
68	Sterile Drape for Mayo Stand	SB012	1				1	
69	gauze, sterile 4in x 4in	SG055					6	
70	povidone soln (Betadine)	SJ041					60	
71	lidocaine 1%-2% inj (Xylocaine)	SH047					20	
72	sodium chloride 0.9% flush syringe	SH065					2	
73	Tunneler	No Code					1	
74	scalpel with blade, surgical (#10-20)	SF033					1	
75	catheter percutaneous fastener (Percu-Stay)	SD146					1	
76	needle, 18-27g	SC029					2	
77	Suction Cannister	3D010	1					
78	Suction Vacuum	SD010	1					
79	Catheter Insertion Kit 50-7000* -- $329.00	SA077	1					
80	Vacuum Bottle 50-7205 -- $31 00	No code	2					
81	Peritoneal Dialysis Catheter	No Code					1	
82	Peritoneal Dialysis Sterile Solution	No Code					1	
83	Y-set connection tubing	No code					1	
84	kit, AccuStick II Introducer System with RO Marker	SA071					1	
85	dilator, vessel, angiographic	SD043					1	
86	sheath, peel away	SD206					1	
87	Micropore Tape	SG079	32 in				32 in	
88	Disinfectant	SM012			10 cc		10 cc	
89	Film jacket or jacket insert	No code			1		1	
90	Film, 14x17, laser	SK098			1		1	
91	Gloves, non-sterile	SB022			1			
92	cdrom	SK013			1		1	
93	cover-condom, transducer or ultrasound probe	SB005			1		1	
94	**Equipment**							
95	Power Exam Table	EF031	X					
96	Mayo Stand	EF015	X				136.0	
97	Exam Lamp	EQ168	X				136 0	
98	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011	X				136.0	
99	Portable ultrasound machine	New Code					136.0	
100	Radiographic-fluoroscopic room	EL014					76.0	
101	film alternator	ER029	x		x		55.0	
102	film processor	ED024	x				55.0	
103	laser printer	ED032			x		9	

1015

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
000, 010, or 090 Day Global Periods
Direct Inputs

CPT Long Descriptor:

GLOBAL	CPT	DESCRIPTOR
0	49421	Insertion of tunneled intraperitoneal catheter for dialysis; open

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
A panel of general surgeons considered the direct practice expense inputs related to 49421 as a 0-day global code and determined that minimal clinical staff time only is related to this facility only service.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The global period will not impact the typical 5 minutes for diagnostic and referral forms necessary to perform this service, compared with a 90-day global procedure. Scheduling facility space and equipment/supplies an the surgeons availability will require at least one phone call (3 min).

Intra-Service Clinical Labor Activities:

Clinical staff communicates with the facility staff, patient's family, insurance staff, and PCP/referring physician regarding discharge instructions and follow-up requirements. The standard 6-minutes for follow-up phone calls.

Post-Service Clinical Labor Activities: **N/A**

	A	B	C	D	E
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**Apr 2010**	
2	**Meeting Date: April 2010**			**49421**	
3				Insertion of tunneled intraperitoneal catheter for dialysis; open	
4	**LOCATION**	**Code**	**Staff Type**	**OFF**	**FAC**
5	**GLOBAL PERIOD**			**0**	**0**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**0**	**14**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**0**	**8**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**0**	**0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**0**	**6**
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		**0**
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA		**3**
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA		**0**
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA		**0**
17	Other Clinical Activity (please specify)	**L037D**	RN/LPN/MTA		
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**				
38	Discharge day management	**L037D**	RN/LPN/MTA	**0**	**0**
40	**End: Patient leaves office**				
41	**POST-SERVICE Period**				
42	**Start: Patient leaves office/facility**				
43	Conduct phone calls/call in prescriptions				**6**
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	**Equipment**	**Code**	**None**		

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
February 2010
Originated from the Five Year Review – Site-of-Service Anomaly Screen

Vaginal Radiation Afterloading Apparatus for Clinical Brachytherapy

In September 2007, the RUC identified CPT Code 57155 *Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy* (090 day global, Work RVU = 6.78) through its Site of Service Anomaly Screen and recommended to CMS that the service be changed to a 010 day global service and that its physician discharge day management time be halved. The specialty believed that the typical patient may have changed requiring modification to the descriptor, and the service was referred to the CPT Editorial Panel. In October 2009 the CPT Editorial Panel added a new code to report the insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy and revised 57155 to indicate insertion of a single tandem rather than tandems. CMS changed the global period of 57155 from a 090 day to a 000 day global service for 2011.

1019

57155 *Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy*
The RUC reviewed the specialty society's survey results and questioned the specialty in order to obtain a clear understanding of the intra-service and post-operative work time, intensities, and complexities of this revised service. The RUC reviewed the survey data physician time from data 69 radiation oncologists, obstetricians and gynecologists, and agreed that most of the time components reflected the typical current practice. The specialty recognized the need for an additional four minutes of pre-service positioning time with standard pre-time package 2B – facility difficult patient/straightforward procedure with sedation/anesthesia, for at total pre-service time of 43 minutes. The RUC also agreed with the specialty that the respondents underestimated the immediate post service time, and that 30 minutes is typical rather than 20 and corresponds with the 75th percentile of the survey results.

The RUC reviewed the survey's key reference service 55920 *Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application* (work RVU = 8.31, 000 day global, 90 minutes intra-service time) as a comparable service and noted that less than 40% of the respondents chose this code. The RUC reviewed additional services with similar physician work and time, including: 50382 *Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation* (000 global, Work RVU = 5.50, 60 minutes intra-service), 52001 *Cystourethroscopy with irrigation and evacuation of multiple obstructing clots* (000 global, Work RVU = 5.44, 60 minutes intra-service). Based on the 25th percentile survey results (5.80 RVUs) and the above RUC reviewed comparison services, the committee agreed that a value of 5.40 work relative value units would appropriately rank order 57155 within the radiation oncology family of services and across specialties.

The RUC agreed that the reduction in the work value from 6.87 to 5.40, with 60 minutes of intra-service time and intensity is appropriate given the new RUC survey data, and other reference services. **The RUC recommends a relative work value of 5.40 for CPT code 57155.**

57156 ***Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy***
The RUC reviewed the survey results from 60 physicians familiar with this service and agreed that most of the time components reflected the typical current practice. The specialty recognized the need for an additional four minutes of pre-service positioning time with standard pre-time package 2A – difficult patient/straightforward procedure no sedation/anesthesia care) for at total pre-service time of 29 minutes. The RUC also agreed with the specialty that the respondents underestimated the immediate post service time, and that 20 minutes rather than 15, is typical and corresponds with the 75th percentile of the survey results.

The RUC reviewed the survey's key reference service 19296 *Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy* (work RVU = 3.63, 000 day global, 30 minutes intra-service time) as a comparable service and agreed that is was a more difficult and time consuming service than the surveyed code. The RUC reviewed additional services with similar physician work and time, including; MPC code 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)* (000 day global, Work RVU = 3.69, 30 minutes intra-service) and 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (000 day global, Work RVU= 2.78, 30 minutes of intra-service time). It was agreed that the survey respondents overestimated the physician work of 57156 and the 25th percentile survey results (2.69 work RVUs) were more appropriate for the time, intensity, and complexity the physician would endure. In comparison services, the RUC agreed that a value of 2.69 work relative value units would appropriately rank order 57156. **The RUC recommends the specialty's 25th percentile survey work relative value of 2.69 for new code 57156.**

Practice Expense: The RUC reviewed the specialty recommended direct practice expense inputs for the non-facility and facility settings and eliminated clinical labor time that was duplicative with evaluation and management services and the medical supplies and equipment was edited for the typical patient service.

Moderate Sedation: The RUC recommends that CPT code 57155 be placed on CPT's Appendix G as moderate sedation is inherent in this procedure.

1020

Work Neutrality: The RUC's recommendation for these 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
● 57156	O1	Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy	000	2.69
▲57155	O2	Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy	000	5.40

1021

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:57156 Tracking Number O1 Specialty Society Recommended RVU: **3.50**
Global Period: 000 RUC Recommended RVU: **2.69**

CPT Descriptor: Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 62-year-old female underwent hysterectomy for postmenopausal bleeding and is found to have Stage I B adenocarcinoma of the endometrium, grade 3 with lower uterine segment involvement. Patient received 50Gy external beam radiation and now is to undergo intravaginal insertion of the radiation afterloading device for delivery of a vaginal cuff radiation boost.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 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? 33%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The pre-service work includes dictating an admission history and physical and writing the admission orders. The patient is greeted in the holding area with appropriate consents verified or taken. All preoperative laboratory and x-ray studies are reviewed. The radiation records are reviewed for fields, tumor dose-to-date, and evaluation of current normal tissue doses. The patient is placed in the lithotomy position and prepped and draped.

Description of Intra-Service Work: A pelvic examination is performed. A Foley catheter with contrast is placed in the bladder. A Rectal tube is placed in the rectum. Retractors are placed in the vagina and the vaginal cuff is visualized. The physician determines the largest possible size device that can be accommodated for the patient anatomy after dilatation to release post radiation adhesions. A vaginal cylinder, or other multichannel device, is selected and assembled with the appropriate length and width. The chosen device is inserted into the vagina, and assessed for fit and stability. Device modifications may be required depending on this fit or packing may be required if vaginal ovoids are used. X-ray images are then taken to confirm placement and adjustments are made as required. Measurements of the position of the applicator in relation to the perineum are made and recorded. The applicator base plate, or other securing mechanism, is attached on the end of the procedure table and the brachytherapy applicator adjusted. The final position is fixed by tightening t applicator base plate locking mechanism.

Description of Post-Service Work: The patient is accompanied to the recovery area where orders are written and the procedure report is dictated. The physician discusses the technical aspects of the insertion procedure including the choice of applicator and connector geometry with the medical physics personnel. The patient is prepared for transfer for simulation

and computer planning and subsequent radiation after loading. Following treatment the device and foley catheter are removed and the vagina inspected for bleeding and lacerations. Home care instructions for care of the perineum, bowel, and bladder function are provided to the patient and prescriptions are written or called to the pharmacy. Instruction on use of vaginal dilator is given . Additional radiation is scheduled and coordinated with staff and other physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010		
Presenter(s):	ASTRO: Najeeb Mohideen, MD, Michael Kuettel, MD, PhD and Thomas Eichler, MD ACOG: George Hill, MD and Rusty Robinson, MD		
Specialty(s):	Radiation Oncology and Gynecologic Oncology		
CPT Code:	57156		
Sample Size: 1139	**Resp N:** 60	**Response:** 5.2 %	
Sample Type: Random	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.75	**10.00**	20.00	200.00
Survey RVW:	1.00	2.69	**3.50**	3.80	20.00
Pre-Service Evaluation Time:			**25.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**6.50**		
Intra-Service Time:	10.00	20.00	**30.00**	33.75	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: 2a-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	57156	**Recommended Physician Work RVU: 2.69**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**18.00**	**18.00**	**0.00**
Pre-Service Positioning Time:		**5.00**	**1.00**	**4.00**
Pre-Service Scrub, Dress, Wait Time:		**6.00**	**6.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**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:

; this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
19296	000	3.63	**RUC Time**

CPT Descriptor Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
45378	000	3.69	**RUC Time**	971,248

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: 25 **% of respondents:** 41.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 57156**	**Key Reference CPT Code: 19296**	**Source of Time RUC Time**
Median Pre-Service Time	29.00	55 00	
Median Intra-Service Time	30.00	30.00	
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	0.0	19.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**79.00**	**119.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.56	3.52
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.60	3.52
Urgency of medical decision making	3.16	3.16
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.32	3.72
Physical effort required	3.24	3.32
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.60	3.36
Outcome depends on the skill and judgment of physician	3.56	3.48
Estimated risk of malpractice suit with poor outcome	3.16	3.12

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.24	3.28
Intra-Service intensity/complexity	3.44	3.72
Post-Service intensity/complexity	3.48	3.36

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendatio for the appropriate formula and format.*

BACKGROUND

This is a new CPT code, resulting from the review of CPT code 57155 which was identified through the 5 Year Review Subcommittee site of service anomaly filter. This new CPT code was developed to describe the insertion of a vaginal apparatus for clinical brachytherapy.

RECOMMENDATIONS

Two societies conducted RUC surveys for this CPT code (ASTRO and ACOG). There were 60 completed surveys (23 ACOG and 37 ASTRO). The two societies formed a consensus panel to review the survey data. The Consensus Panel reviewed the ASTRO data set, the ACOG data set and the Blended data set. The data were consistent at the organization level and after blending.

The consensus panel carefully considered surveyed data, IWPUT, site of service and the history of this code. The consensus panel recommends that CPT code 57156 be valued at 3.5 RVUs (survey median).

We recommend the following times:

PRE: 29 minutes (difficult patient/straightforward procedure (NO sedation/anesthesia care) (Facility Package 2A)) INCREASED by 4 minutes for positioning time

INTRA: 30 minutes and

POST: 34 minutes (15 minutes immediate post and 19 minutes post (½ Discharge Day Mgmt))

The IWPUT with our recommended times is 0.06534. This IWPUT is reasonable and appropriate compared to other similar CPT codes.

Work neutrality was also considered when finalizing the specialty society's recommendations. The societies are recommending a decrease in work RVUs for CPT code 57155. In addition, a number of procedures currently billed to Medicare with 57155 will now be reported with the new CPT code 57156. Those procedures, along with the vaginal brachy procedures billed with 58999 or 58346 will have considerably lower work RVUs under this proposal.

SERVICES REPORTED WITH MULTIPLE 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.

	Work RVU	Global	Pre	Intra	Post	Total
77785	1.42	XXX	11	30	10	51
77290	1.56	XXX		70		70

7.	77300	0.62	XXX	15	15
8.	77336	0.00	XXX		
9.	77326	0.93	XXX		35

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 58999, 57155, 58346

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiation Oncology How often? Sometimes

Specialty Gynecologic Oncology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4300
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 data for total hysterectomies supports our estimations, as a percentage of those hysterectomy cases with endometrial cancer will receive postoperative radiation. Then, we considered that this procedure is done about 70% of the time on Medicare patients. Finally, we then determined the specialty breakdown by looking at the Medicare claims data for CPT code 57155 in the RUC database and determined that the RO would be performing this procedure approximately 80% of the time.

Specialty Radiation Oncology Frequency 3440 Percentage 80.00 %

Specialty Gynecologic Oncology Frequency 860 Percentage 20.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 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.

Specialty Radiation Oncology Frequency 2400 Percentage 80.00 %

Specialty Gynecologic Oncology Frequency 600 Percentage 20.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 19296

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:57155 Tracking Number O2 Specialty Society Recommended RVU: **6.20**
Global Period: 000 RUC Recommended RVU: **5.40**

CPT Descriptor: Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 49-year-old patient with Stage II B cervical cancer has completed her external beam radiation and chemotherapy. She is now scheduled for placement of tandems and ovoids for brachytherapy for completion of her radiation therapy. [Note: Consider only work related to placing the tandem and ovoids. The work of afterloading the radiation sources is captured in other, separately reported codes.]

Percentage of Survey Respondents who found Vignette to be Typical: 99%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 57%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 67%

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 dictating an admission history and physical, evaluating response to external radiation and suitability for tandem and ovoid insertion and writing the admission orders. The patient is greeted in the preoperative holding area with appropriate consents verified or taken. The radiation records are reviewed for fields, tumor dose-to-date and evaluation of current normal tissue doses. Discuss plan with Anesthesiologist, nursing, brachytherapy team and other staff. All preoperative laboratory and x-ray studies are reviewed. Select, assemble and if necessary order requisite catheters/supplies. The patient is placed in the lithotomy position and prepped and draped.

Description of Intra-Service Work: A time out performed. A complete pelvic exam is performed. Foley catheter is placed in the bladder. Retractors are placed in the vagina and the cervix is visualized. A single tooth tenaculum is applied to the anterior lip of the cervix. The external os which is generally distorted by the tumor or radiation effects has to be identified with certainty. The uterine sound is then used and the central canal of the uterus is measured. The cervix is dilated using Hegar dilators An appropriately curved uterine tandem is selected based on the patient anatomy and the flange marker on the tandem is adjusted to match the desired insertion depth. The tandem (hollow tube) is inserted into the uterus taking care to avoid perforation. The other end of the tandem is left protruding through the vaginal introitus. A right and left ovoid (or comparable ring apparatus) are then are placed in the vaginal fornices and tested for optimal fit. They are removed as necessary and the cap size modified to correctly match the patient's anatomy. The final ovoid assembly is re-inserted and fixed to the tandem (and tenaculum) using a central locking mechanism. They are repositioned in the new,

locked position as necessary to preserve the geometry. A posterior vaginal paddle (rectal displacement retractor) may be inserted and attached to the tandem and ovoids. Measurements of the relative position of the applicator parts and relationship to the perineum are made and recorded. Lubricated vaginal gauze packing is used to secure the applicator and to further displace the bladder and rectum away from the planned radiation source position. AP and lateral x-ray images are then taken to confirm placement or if adjustment is required (due to the position and relationship of the tandem and ovoid the separation of the ovoids or position of the apparatus relative to bladder and rectum) the pack is removed and the tandem and ovoid positions are adjusted till satisfactory on repeat imaging studies. A perineal suture or fixation device is placed to secure the final position.

Description of Post-Service Work: The patient is accompanied to the recovery room where postoperative orders are written and the operative report is dictated. Meet with patient's family. The patient is prepared for transfer to the treatment area for simulation, computer planning and subsequent radiation after loading. At the conclusion of the treatment procedure a report generated. Perineal sutures and packing are then removed. The tandem and ovoids are disassembled and individually removed. The vagina and cervix are inspected for injury. Patient is then assisted up from the lithotomy position to a sitting, and then standing position while being monitored. Home care instructions for care of the perineum, bowel, and bladder function are provided to the patient and prescriptions are written. Instruction on use of vaginal dilator is also given. Additional radiation treatment is scheduled and coordinated with staff and other physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	ASTRO: Najeeb Mohideen, MD, Michael Kuettel, MD, PhD and Thomas Eichler, MD ACOG: George Hill, MD and Rusty Robinson, MD				
Specialty(s):	Radiation Oncology and Gynecologic Oncology				
CPT Code:	57155				
Sample Size:	1139	**Resp N:**	69	**Response:** 6.0 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	6.00	**10.00**	20.00	200.00
Survey RVW:	1.00	5.80	**6.20**	8.00	13.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	10.00	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:	**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:	57155	**Recommended Physician Work RVU: 5.40**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**5.00**	**1.00**	**4.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
55920	000	8.31	**RUC Time**

CPT Descriptor Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
43269	000	8.20	**RUC Time**	17,409

CPT Descriptor 1 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent

MPC CPT Code 2	Global	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: 27 **% of respondents:** 39.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 57155**	**Key Reference CPT Code:** 55920	**Source of Time** RUC Time
Median Pre-Service Time	43.00	55.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**133.00**	**175.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.93	4.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.37
Urgency of medical decision making	3.63	3.89
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.26	4.78
Physical effort required	4.11	4.56
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.11	4.70
Outcome depends on the skill and judgment of physician	4.30	4.70
Estimated risk of malpractice suit with poor outcome	4.15	4.41

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	4.11
Intra-Service intensity/complexity	4.22	4.78
Post-Service intensity/complexity	3.85	4.15

Additional Rationale and Comments

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 Recommendations for the appropriate formula and format.*

BACKGROUND

This code was identified through the 5 Year Review Subcommittee site of service anomaly filter as this procedure has migrated from the hospital inpatient setting to the hospital outpatient setting. As such, the Subcommittee sent the code to CPT for review. The descriptor for 57155 was maintained and the vignette was updated. A new CPT code was developed to describe the insertion of a vaginal apparatus for clinical brachytherapy.

RECOMMENDATIONS

Two societies conducted RUC surveys for this CPT code (ASTRO and ACOG). There were approximately 70 completed surveys (30 ACOG and 39 ASTRO). The two societies formed a consensus panel to review the survey data. The Consensus Panel reviewed the ASTRO data set, the ACOG data set and the Blended data set. The data were consistent at the organization level and after blending.

The consensus panel carefully considered surveyed data, IWPUT, site of service and the history of this code. The consensus panel recommends that CPT code 57155 be valued at 6.2 RVUs (survey median) a reduction from the current 6.79 RUV value.

We recommend the following times:

PRE: 43 minutes (difficult patient/straightforward procedure (with sedation/anesthesia care) (Facility Package 2B)) INCREASED by 4 minutes for positioning time

INTRA: 60 minutes and

POST: 39 minutes (20 minutes immediate post and 19 minutes post (½ Discharge Day Mgmt))

The IWPUT with our recommended times is 0.07034. This IWPUT is reasonable and appropriate compared to other similar CPT codes. For example, our reference code 55920 (recently RUC'ed) has an IWPUT of 0.07356. The surveyed code has a slightly lower IWPUT which is supported by the consensus panel and the survey data. Another comparison would be to CPT code 41019 *Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application* (recently RUC'ed). That CPT code, another insertion code for clinical brachytherapy, has an IWPUT of 0.07945. The Consensus Panel agreed that the surveyed code has a lower IWPUT than CPT code 41019.

Work neutrality was also considered when finalizing the specialty society's recommendations. The societies are recommending a decrease in work RVUs for CPT code 57155. In addition, a number of procedures currently billed to Medicare with 57155 will now be reported with the new CPT code 57156. Those procedures, along with the vaginal brachy procedures billed with 58999 or 58346 will have considerably lower work RVUs under this proposal.

SERVICES REPORTED WITH MULTIPLE 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.

	Work RVU	Global	Pre	Intra	Post	Total
77786	3.25	XXX	14	60	15	89
77290	1.56	XXX		70		70
77300	0.62	XXX		15		15
77336	0.00	XXX				
77328	2.09	XXX				55

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 57155

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiation Oncology How often? Sometimes

'pecialty Gynecologic Oncology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 6000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We looked at the 2009 Medicare utilization data to confirm similar rate of growth. We also took into account that some of the procedures currently billed to Medicare with 57155 will now be reported with the new CPT code 571xx. Then, we considered that this procedure is done about 50% of the time on Medicare patients. Finally, we then determined the specialty breakdown by looking at the Medicare claims data for CPT code 57155 in the RUC database.

Specialty Radiation Oncology Frequency 4200 Percentage 70.00 %

Specialty Gynecologic Oncology Frequency 1800 Percentage 30.00 %

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.

Specialty Radiation Oncology Frequency 2100 Percentage 70.00 %

pecialty Gynecologic Oncology Frequency 900 Percentage 30.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 19298

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

	A	B	C	D	E	F	G
1				57156		57155	
2	**Meeting Date: February 2010** **Specialty: Radiation Oncology**	**CMS**	**Staff**	**Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy**		**Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**						
5	**TOTAL CLINICAL LABOR TIME**			**65.0**	**18.0**	**183.0**	**18.0**
6		**L037D**	**RN/LPN/MTA**	35 0		46.0	
7		**L050C**	**Rad Therapist**	30 0		60.0	
8		**L051A**	**RN**			77.0	
9	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**4.0**	**18.0**	**15.0**	**18.0**
10	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**58.0**		**165.0**	
11		L037D	RN/LPN/MTA	28 0	0 0	28.0	0 0
12		L050C	Rad Ther	30 0		60.0	
13		L051A	RN			77 0	
14	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**3.0**	**0.0**	**3.0**	**0.0**
15	**PRE-SERVICE**						
16	**Start: Following visit when decision for surgery or procedure made**						
17	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MA		5	5	5
18	Coordinate pre-surgery services	L037D	RN/LPN/MA		3	3	3
19	Schedule space and equipment in facility	L037D	RN/LPN/MA		3		3
20	Provide pre-service education/obtain consent	L037D	RN/LPN/MA	4	4	4	4
21	Follow-up phone calls & prescriptions	L037D	RN/LPN/MA		3	3	3
22	Other Clinical Activity (please specify)						
23	**End: When patient enters office/facility for surgery/procedure**						
24	**SERVICE PERIOD**						
25	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**						
27	Greet Patient and Provide Gowning, Assure Appropriate Medical Records Are Available	L037D	RN/LPN/MA	1		1	
28	Obtain vital signs	L037D	RN/LPN/MA	0		0	
29	Provide pre-service education/obtain consent						
30	Prepare room, equipment, supplies	L037D	RN/LPN/MA	2		2	
31	Setup scope (non facility setting only)						
32	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MA	2		2	
33	Sedate/apply anesthesia	L037D	RN/LPN/MA	2			
34	Sedate/apply anesthesia	L051A	RN			2	
35	**Intra-service**						
36	Assist physician in performing procedure	L050C	RT	30		60	
37	Assist physician in performing procedure	L037D	RN/LPN/MA	5			
38	Assist physician in performing procedure (CS)	L051A	RN			60	
39	**Post-Service**						
40	Monitor pt following service/check tubes, monitors, drains	L037D	RN/LPN/MA	**3**			
41	Monitor pt following service/check tubes, monitors, drains	L051A	RN			15	
42	Clean room/equipment by physician staff	L037D	RN/LPN/MA	**3**		3	
43	Clean Scope						
44	Clean Surgical Instrument Package	L037D	RN/LPN/MA			10	
45	Complete diagnostic forms, lab & X-ray requisitions						
46	Review/read X-ray, lab, and pathology reports						
47	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
48	Discharge day management						
49	Other Clinical Activity (please specify) *Clean Applicator/T&O Set*	L037D	RN/LPN/MA	10		10	
50	**End: Patient leaves office**						
51	**POST-SERVICE Period**						
52	**Start: Patient leaves office/facility**						
53	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MA	3		3	
54	*Office visits.*						
55	*List Number and Level of Office Visits*						
56	99211 16 minutes		16				
57	99212 27 minutes		27				

	A	B	C	D	E	F	G
1				57156		57155	
2	**Meeting Date: February 2010** **Specialty: Radiation Oncology**	**CMS**	**Staff**	**Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy**		**Insertion of uterine tandem and/or vaginal ovoids for clinic brachytherapy**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
58	99213 36 minutes		36				
59	99214 53 minutes		53				
60	99215 63 minutes		63				
61	Other						
62	*Total Office Visit Time*			**0**	**0**	**0**	**0**
63	Other Activity (please specify)						
64	**End: with last office visit before end of global period**						
65	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**				
66	pack, minimum multi-specialty visit	SA048		1		1	
67	pack, pelvic exam	SA051		1		1	
68	pack, cleaning, surgical instruments	SA043		1		1	
69	tray, catheter insertion (w-o catheter)	SA063		1		1	
70	Conscious Sedation Medical Supply Package	SA044		NO		1	
71	gown, ~~sterile~~ staff, impervious	SB027		2		2	
72	gloves, ~~sterile~~ nonsterile	SB022		2		2	
73	drape, non-sterile, sheet 40in x 60in	SB006		1		1	
74	mask, surgical, with face shield	SB034		1		1	
75	underpad 2ft x 3ft (Chux)	SB044		1		1	
76	gauze, non-sterile 4in x 4in	SG051		2			
77	catheter, Foley	SD024		1		1	
78	**Equipment**	**CMS Code**					
79	T&O Applicator Set			**N/A**		80.0	
80	Vag Applicator Set			53.0		**N/A**	
81	Table, brachytherapy treatment	EF021		43.0		70 0	
82	Stirrups for brachytherapy table	ER062		43.0		70.0	
83	light, fiberoptic headlight w-source	EQ170		43.0		70.0	
84	Surgical Instrument Package - Basic Tray	EQ137		N/A		80.0	
85	Applicator Base Plate			43 0		70.0	
86	cardio-respiratory monitor					70 0	
87	infusion pump					70 0	
88	pulse oximeter					70.0	

	A	B	C	D	E	F	G
1				57156		57155	
2	**Meeting Date: February 2010**	**CMS**	**Staff**	**Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy**		**Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**						
5	**TOTAL CLINICAL LABOR TIME**			**65.0**	**18.0**	**183.0**	**18.0**
6		**L037D**	**RN/LPN/MTA**	35.0		46.0	
7		**L050C**	**Rad Therapist**	30.0		60.0	
8		**L051A**	**RN**			77.0	
9	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**4.0**	**18.0**	**15.0**	**18.0**
10	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**58.0**		**165.0**	
11		L037D	RN/LPN/MTA	28.0	0 0	28.0	0.0
12		L050C	Rad Ther	30 0		60.0	
13		L051A	RN			77 0	
14	**TOTAL POST-SERV CLINICAL LABOR TIME**	L037D	RN/LPN/MTA	**3.0**	**0.0**	**3.0**	**0.0**
15	**PRE-SERVICE**						
16	**Start: Following visit when decision for surgery or procedure made**						
17	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MA		5	5	5
18	Coordinate pre-surgery services	L037D	RN/LPN/MA		3	3	3
19	Schedule space and equipment in facility	L037D	RN/LPN/MA		3		3
20	Provide pre-service education/obtain consent	L037D	RN/LPN/MA	4	4	4	4
21	Follow-up phone calls & prescriptions	L037D	RN/LPN/MA		3	3	3
22	Other Clinical Activity (please specify)						
23	**End: When patient enters office/facility for surgery/procedure**						
24	**SERVICE PERIOD**						
25	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**						
27	Greet Patient and Provide Gowning, Assure Appropriate Medical Records Are Available	L037D	RN/LPN/MA	1		1	
28	Obtain vital signs	L037D	RN/LPN/MA	0		0	
29	Provide pre-service education/obtain consent						
30	Prepare room, equipment, supplies	L037D	RN/LPN/MA	2		2	
31	Setup scope (non facility setting only)						
32	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MA	2		2	
33	Sedate/apply anesthesia	L037D	RN/LPN/MA	2			
34	Sedate/apply anesthesia	L051A	RN			2	
35	**Intra-service**						
36	Assist physician in performing procedure	L050C	RT	30		60	
37	Assist physician in performing procedure	L037D	RN/LPN/MA	5			
38	Assist physician in performing procedure (CS)	L051A	RN			60	
39	**Post-Service**						
40	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MA	**3**			
41	Monitor pt. following service/check tubes, monitors, drains	L051A	RN			15	
42	Clean room/equipment by physician staff	L037D	RN/LPN/MA	**3**		3	
43	Clean Scope						
44	Clean Surgical Instrument Package	L037D	RN/LPN/MA			10	
45	Complete diagnostic forms, lab & X-ray requisitions						
46	Review/read X-ray, lab, and pathology reports						
47	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
48	Discharge day management						
49	Other Clinical Activity (please specify) *Clean Applicator/T&O Set*	L037D	RN/LPN/MA	10		10	
50	**End: Patient leaves office**						
51	**POST-SERVICE Period**						
52	**Start: Patient leaves office/facility**						
53	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MA	3		3	
54	*Office visits*						
55	*List Number and Level of Office Visits*						
56	99211 16 minutes		16				
57	99212 27 minutes		27				

	A	B	C	D	E	F	G
1				57156		57155	
2	**Meeting Date: February 2010**	**CMS**	**Staff**	**Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy**		**Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
58	99213 36 minutes		36				
59	99214 53 minutes		53				
60	99215 63 minutes		63				
61	Other						
62	*Total Office Visit Time*			**0**	**0**	**0**	**0**
63	Other Activity (please specify)						
64	**End: with last office visit before end of global period**						
65	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**				
66	pack, minimum multi-specialty visit	SA048		1		1	
67	pack, pelvic exam	SA051		1		1	
68	pack, cleaning, surgical instruments	SA043		1		1	
69	tray, catheter insertion (w-o catheter)	SA063		1		1	
70	Conscious Sedation Medical Supply Package	SA044		NO		1	
71	gown, ~~sterile~~ staff, impervious	SB027		2		2	
72	gloves, ~~sterile~~ nonsterile	SB022		2		2	
73	drape, non-sterile, sheet 40in x 60in	SB006		1		1	
74	mask, surgical, with face shield	SB034		1		1	
75	underpad 2ft x 3ft (Chux)	SB044		1		1	
76	gauze, non-sterile 4in x 4in	SG051		2			
77	catheter, Foley	SD024		1		1	
78	**Equipment**	**CMS Code**					
79	T&O Applicator Set			**N/A**		80.0	
80	Vag Applicator Set			53.0		**N/A**	
81	Table, brachytherapy treatment	EF021		43 0		70.0	
82	Stirrups for brachytherapy table	ER062		43.0		70 0	
83	light, fiberoptic headlight w-source	EQ170		43 0		70 0	
84	Surgical Instrument Package - Basic Tray	EQ137		N/A		80.0	
85	Applicator Base Plate			43.0		70.0	
86	cardio-respiratory monitor					70 0	
87	infusion pump					70.0	
88	pulse oximeter					70.0	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five-Year Review – CMS Fastest Growing Screen

February 2010

Stereotactic Computer-Assisted Volumetric Navigational Procedures

In October 2008, 61795 *Stereotactic computer-assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal* (Work RVU = 4.03) was identified for potential misvaluation through the CMS Fastest Growing Screen. The RUC and the specialty societies determined that the work and technology related to intracranial, extracranial and spinal procedures may be different. Thus, the specialty societies submitted a code change proposal to the CPT Editorial Panel and 61795 was deleted and three new codes were created to separately report cranial intradural, cranial extradural and spinal.

61781

The RUC reviewed the survey results for code 61781 *Stereotactic computer assisted (navigational) procedure; cranial, intradural* and agreed with the specialty societies that the survey respondents overstated the pre-service time and physician work. The specialty explained that this add-on procedure is difficult to separate the pre-service evaluation time between the surveyed code and the primary procedure. The RUC, as is typical for many neurosurgical procedures, recommends 15 minutes of pre-service evaluation due to the high intensity and complexity of this procedure.

In addition, the RUC reviewed the median survey time of 4.50 RVUs and agreed with the specialties that it is not reflective of the service. The RUC compared the surveyed code to the key reference code 20985 *Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less* (Work RVU = 2.50, ZZZ global period) and noted that the surveyed code has an additional 5 minutes of pre-service time and 10 additional minutes of intra-service time. It was also noted that the survey respondents scored 61781 higher in every intensity and complexity measure compared to the key reference code.

Finally, to maintain appropriate relatively amongst similar services, the RUC compared 61781 to MPC code 60512 *Parathyroid autotransplantation* (Work RVU = 4.44, intra-service time = 45 minutes). The RUC agreed with the specialty that this reference code has more intra-service time and is a more complex procedure. Based on these comparisons to CPT codes 20985 and 60512, 3.75 Work RVUs, slightly higher than the 25th percentile, accurately reflects the work required to perform this service. **The RUC recommends 3.75 Work RVUs for 61781.**

61782
The RUC reviewed the survey results for code 61782 *Stereotactic computer assisted (navigational) procedure; cranial, extradural* and agreed with the specialty societies that the survey respondents overstated the pre-service time and median physician work. The RUC, as is typical for many neurosurgical procedures, recommends 15 minutes of pre-service time due to the high intensity and complexity of this procedure.

In addition, the RUC reviewed the median survey time of 3.50 RVUs and agreed with the specialties that it is not reflective of the service. The RUC compared the surveyed code to the key reference code 20985 *Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less* (Work RVU = 2.50) and noted that the surveyed code has an additional 5 minutes of pre-service time and 5 additional minutes of intra-service time. It was also noted that the survey respondents scored the surveyed code higher in many of the intensity and complexity measures compared to the reference code.

Finally, to maintain appropriate relatively amongst similar services, the RUC compared 61782 to MPC code 22525 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body* (Work RVU = 4.47, intra-service time = 40 minutes). The RUC agreed with the specialty that this reference code has more intra-service time and is a more complex procedure. The RUC also noted that this service has 25 minutes intra-service time compared to 30 minutes for the other codes in the family (61781 and 61783) and recommends a value lower than these services. Based on the above comparisons, 3.18 Work RVUs, in between the 25th percentile and median survey physician work estimates, accurately reflects the work required to perform this service. **The RUC recommends 3.18 Work RVUs for 61782.**

1050

61783
The RUC reviewed the survey results for code 61783 *Stereotactic computer assisted (navigational) procedure; Spinal* and agreed with the specialty societies that the survey respondents overstated the pre-service time and median physician work. The RUC recommends 15 minutes of pre-service time due to the intensity and complexity of this procedure.

In addition, the RUC reviewed the median survey time of 5.00 RVUs agreed with the specialties that it is not reflective of the service. The RUC compared the surveyed code to the key reference code 20985 *Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less* (Work RVU = 2.50) and noted that the surveyed code has an additional 5 minutes of pre-service time and 10 additional minutes of intra-service time. It was also noted that the survey respondents scored the surveyed code higher in many of the intensity and complexity measures compared to the reference code.

Finally, to maintain appropriate relatively amongst similar services, the RUC compared 61783 to MPC code 60512 *Parathyroid autotransplantation* (Work RVU = 4.44, intra-service time = 45 minutes). The RUC agreed with the specialty that this reference code has more intra-service time and is a more complex procedure. Based on these comparisons to CPT codes 20985 and 60512, 3.75 Work RVUs, a value slightly higher than the 25th percentile, accurately reflects the work required to perform this service. **The RUC recommends 3.75 Work RVUs for 61783.**

Practice Expense
The RUC agreed that there would be no direct practice expense inputs for these services as they are add-on services performed in a facility setting.

Work Neutrality
The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

1051

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
+●61781	P1	Stereotactic computer assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure) (Do not report 61781 in conjunction with 61720-61791, 61796-61799, 61863-61868, 62201, 77371-77373, 77432)	ZZZ	3.75
+●61782	P2	cranial, extradural (List separately in addition to code for primary procedure) (Do not report 61781, 61782 by the same provider during the same surgical session)	ZZZ	3.18

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
+●61783	P3	spinal (List separately in addition to code for primary procedure) (Do not report 61783 in conjunction with 63620, 63621)	ZZZ	3.75
Stereotactic Radiosurgery (Cranial)				
D +61795		~~Stereotactic computer-assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal (List separately in addition to code for primary procedure)~~ (61795 has been deleted. To report, see 61781, 61782, 61783)	ZZZ	N/A

1052

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:61781 Tracking Number P1 Specialty Society Recommended RVU: **3.75**
Global Period: ZZZ RUC Recommended RVU: **3.75**

CPT Descriptor: Stereotactic computer assisted (navigational) procedure; cranial-intradural (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57-year-old male presents with increasing headaches, confusion, and nausea. Examination shows decline in his mini-mental status exam and vertical gaze palsy. A MRI scan demonstrates a tumor in the third ventricle with hydrocephalus. A microsurgical resection is planned with image guidance based on preoperative images.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:
In addition to the standard preoperative discussion with the patient about the surgical procedure, the surgeon reviews the indications and use of stereotactic computer navigation as an adjunct to intracranial tumor surgery. This involves explaining the rationale for the use of the system, how it helps confirm surgical position and avoid damage to surrounding vital structures, volumetric analysis of the operative site, and that the surgery may be somewhat longer and more complicated. [Note: The system is typically reserved for difficult cases in patients with disease in close proximity to the skull base, orbit, neurovascular structures, eloquent cortex, or those with alteration of anatomic landmarks due to previous surgery, trauma, congenital, or neoplastic processes.] Depending on the specific system and application, the explanation includes the use of a head frame or other hardware affixed to the patient's head during the procedure, such as implanted bone fiducial markers.

The computer navigation unit is booted up and the surgeon activates the navigation software, loading and verifying patient formation and confirming image quality. Program options are checked and adjusted as necessary. A detailed assessment of the image set in all three dimensions is performed by the surgeon on the computer workstation to analyze the pathology in relationship to surrounding anatomy, and formulating the navigational plan for the approach and resection of the disease process. Additional imaging studies (eg., functional MRI data) may be obtained separated from the navigational CT or MRI

image set. The physician may use the workstation to merge with the additional image set(s) to the navigation image set to provide additional information for the approach to and resection of the disease process.

Once the patient is positioned on the operating table, the computer navigational unit is moved into place to ensure proper alignment of the camera and intra-operative tracking devices in an unobstructed field of view while allowing the surgeon t see the computer monitor. This includes consideration of position of the computer navigational unit in relation to use o the operating microscope.

Description of Intra-Service Work:
After induction of anesthesia, the head frame or other fiducial hardware is affixed to the patient's skull, taking care to precisely position the apparatus. Surface tracings of the head and facial regions are performed to register and calibrate the device. Verification of navigational accuracy is ascertained by correlating specific surface anatomic sites to the computer-generated images. Registration and calibration may need to be repeated if navigational accuracy is not sufficient. Verification is repeated, after the surgical field has been prepped and draped to confirm accuracy. Use of the operating microscope as a tracking device may be used and the process repeated to register and calibrate the microscope to the fiducial markers and navigational system.

Throughout the procedure, the operative field is visualized, with frequent confirmation of position and relationship to surrounding vital structures provided by placing a tracking device within the operative field, correlating the view with the position indicated by the images on the computer monitor. If used, the view through the operating microscope is also verified by placing a tracking device within the operative field under microscopic view. Based on this information, intra-operative decisions are made to appropriately modify the approach and volumetric resection to help ensure a safe and effective surgical procedure.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	John Wilson, MD; Edward Vates, MD; Alexander Mason, MD				
Specialty(s):	neurosurgery				
CPT Code:	61781				
Sample Size:	1000	**Resp N:**	72	**Response:** 7.2 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	10.00	**20.00**	40.00	300.00
Survey RVW:	2.20	3.00	**4.50**	5.00	9.15
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	20.00	**30.00**	30.00	60.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
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: ZZZ Global Code

CPT Code:	61781	**Recommended Physician Work RVU: 3.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**0.00**	**15.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**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
20985	ZZZ	2.50	**RUC Time**

CPT Descriptor Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (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
		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:** 15.2 %

TIME ESTIMATES (Median)	**CPT Code: 61781**	**Key Reference CPT Code: 20985**	**Source of Time RUC Time**
Median Pre-Service Time	15.00	10.00	
Median Intra-Service Time	30.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**45.00**	**30.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.55	2.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.55	2.36
Urgency of medical decision making	3.00	2.45
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.36	2.73
Physical effort required	2.00	1.91
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.18	2.27
Outcome depends on the skill and judgment of physician	3.73	3.09
stimated risk of malpractice suit with poor outcome	2.64	2.27

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.64	2.36
Intra-Service intensity/complexity	3.00	2.55
Post-Service intensity/complexity	2.00	1.44

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background – Harvard & CPT

The Harvard study reviewed code 61795 for intra-time only, but appears to have been reviewed as the total procedure (not add-on) with a descriptor/vignette of "Stereotactic computer assisted volumetric intracranial procedure." The Harvard study total procedure intra-time is recorded as 239 minutes in the Harvard report. However, it appears that this time was not used to value the procedure. In November 1998, the CMS time file created by a CMS contractor (require for the new methodology for computing resource-based practice expense RVUs) indicates 97 minutes (not 239) for code 61795. The "Time Source" in this file is "OTH" which corresponds to "Remaining services lacking time data were gap filled." Currently, the RUC database still indicates "CMS/Other" for the time of 97 minutes for this code. This information suggests that the current time assigned to code 61795 is an estimate made by CMS for practice expense purposes only.

Through CPT 1999, the descriptor for 61795 was "Stereotactic computer assisted volumetric intracranial procedure (list separately in addition to code for primary procedure)." However, as part of the development of a series of new codes to replace then current deep brain stimulation codes, an editorial change was made in 2000 to the long descriptor of 61795 to add *extracranial* and *spinal* procedures. The short descriptor was not changed and still reads *Brain surgery using computer*.

Background – Physician Fee Schedule

As the table below shows, the global period for 61795 has varied over time, but the work RVUs have not varied. The asterisked note in 1992 further indicates that CMS estimated work for 61795 and that it is not based on survey.

YEAR	CPT	RVW	GLOB	WORK SOURCE
1992	61795	4.25	ZZZ	2*
1993	61795	4.13	000	no rationale in Rule
1994	61795	4.08	000	
1995	61795	4.04	000	
1996	61795	4.04	000	
1997	61795	4.04	000	
1998	61795	4.04	000	
1999	61795	4.04	ZZZ	no rationale in Rule
2009	61795	4.03	ZZZ	

*2 = Physician work value established by HCFA. It may have been a refinement of a Harvard value, or a gap fill for a code for which Harvard did not provide a value. These include codes reviewed by carrier medical directors.

Background – RUC / CPT

In 2008, the RUC 5YR ID WG identified code 61795 through its screen of fastest growing procedures. The AANS/CNS, AAO-HNS, and NASS jointly noted that - *Growth seems to have been driven by use in endoscopic sinus surgery (#1 diagnosis code accounts for almost 1/3 of cases). This is just a broader application of this code and growth seems appropriate and does not indicate change in work. The increase in frequency in Otolaryngology is related to the increase in: 1)Providers being trained; 2)Number of possible revision cases; 3)Cases being identified that fit into the guidelines put forth by the AAO-HNS.* In 2002, the AAO-HNS endorsed the intraoperative use of computer-aided surgery in appropriately select cases to assist the surgeon in clarifying complex anatomy during sinus and skull base surgery. This was re-affirmed in 2005.

The changes in utilization, as shown below, correspond to the timing of the guidelines developed and published by AAO-HNS and the changes in the CPT descriptor to add extracranial and spinal procedures. We also note that it appears utilization has slowed considerably.

2000	2001	2002	2003	2004	2005	2006	2007	2008
6,821	5,938	8,132	10,481	13,032	14,738	17,181	18,122	18,384
	-13%	37%	29%	24%	13%	17%	5%	1%

Although the growth explanation was valid, the RUC 5YR ID WG requested survey of code 61795 because it had never been reviewed. Upon further discussion, the RUC and the specialties determined that the work (and technology) related to intracranial, extracranial, and spinal procedures may be different. A CPT proposal was submitted and the CPT EP

approved deletion of 61795 and creation of three new codes to separate out cranial intradural, cranial extradural, and spinal.

Work RVU Recommendation

The joint specialty expert panel reviewing the survey data for 61781 believe the median RVW of 4.50 overstates the total work and intensity compared to a similar procedure and the reference code 20985. The joint specialty expert panel also believes the survey respondents overestimated the pre-service time as this work is difficult to separate and estimate compared with the pre-service work of the primary procedure. However, the expert panel does believe there is (conservatively) an additional 15 minutes of pre-service work, as described on the first page of this SoR.

To develop a recommendation, the joint specialty expert panel considered the differences in time to recently reviewed code 20985. New code 61781 includes 5 minutes of additional pre-time (5 x 0.0224 = 0.11) and 10 minutes of additional intra-time (10 x 0.114 = 1.14). We are **recommending an RVW of 3.75**, which accounts for these differences (2.50+0.11+1.14). This value is less than the survey median and correctly sets new code 61781 relative to the recently reviewed code 20985 which requires very similar work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Although this code will always be added to another primary procedure, there is no typical or dominant procedure that can be reported here.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 61795

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Commonly

`pecialty 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. not able to estimate

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 9,192
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 50% of current code 61795 2008 Medicare frequency of 18,384

Specialty neurosurgery	Frequency 9192	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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 61797 - intra-time and RVW are closer t recommendation

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:61782 Tracking Number P2 Specialty Society Recommended RVU: **3.18**
Global Period: ZZZ RUC Recommended RVU: **3.18**

CPT Descriptor: Stereotactic computer assisted (navigational) procedure; cranial-extradural (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 51-year-old male presents with nasal polyposis and chronic sinusitis which has failed medical management. A sinus CT shows significant disease involving multiple sinuses with distortion of normal anatomic landmarks. Endoscopic sinus surgery is planned with computer-assisted image guided navigation.

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:
In addition to the standard preoperative discussion with the patient about the surgical procedure, the surgeon spends additional time discussing the use of stereotactic computer navigation as an adjunct to endoscopic sinus surgery. This involves explaining the rationale for the use of the system, how it helps confirm surgical position and avoid damage to surrounding vital structures, and that the surgery may be somewhat longer and more complicated. The system is typically reserved for difficult cases in patients with extensive disease in close proximity to the skull base, orbit, or neurovascular structures, or those with alteration of anatomic landmarks due to previous surgery, trauma, congenital, or neoplastic processes. Depending on the specific system and application, the explanation includes the use of a head frame or other hardware affixed to the patient's head during the procedure.

The computer navigation unit is booted up and the surgeon activates the navigation software, loading and verifying patient information and confirming image quality. Program options are checked and adjusted as necessary. A detailed assessment of the image set in all three dimensions is performed by the surgeon on the computer workstation to analyze the pathology in relationship to surrounding anatomy, formulating plans for both the approach to and resection of the disease process.

Once the patient is positioned on the operating table, the computer navigational unit is moved into place to ensure proper alignment of the camera and intra-operative tracking devices in an unobstructed field of view while allowing the surgeon to see the computer monitor.

Description of Intra-Service Work:
After induction of anesthesia, the head frame or other hardware is affixed to the patient's head, taking care to precisely position the apparatus. Surface tracings of the head and facial regions are performed to register and calibrate the device. Verification of navigational accuracy is ascertained by correlating specific surface anatomic sites to the computer-generated images. Verification is repeated, after the nose has been topically decongested, by correlating intranasal anatomic sites visualized endoscopically.

Throughout the procedure, the operative field is visualized endoscopically, with frequent confirmation of position and relationship to surrounding vital structures provided by placing a tracking device within the operative field, correlating the endoscopic view with the position indicated by the images on the computer monitor. Based on this information, intra-operative decisions are made to appropriately modify the approach and resection to help ensure a safe and effective surgical procedure.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010		
Presenter(s):	John Wilson, MD; Edward Vates, MD; Alexander Mason, MD; Wayne Koch, MD; Bradley, Marple, MD		
Specialty(s):	otolaryngology, neurosurgery		
CPT Code:	61782		
Sample Size: 1156	**Resp N:** 71	**Response:** 6.1 %	
Sample Type: Random	**Additional Sample Information:**		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	5.00	**10.00**	30 00	250.00
Survey RVW:	2.00	2.65	**3.50**	4.50	8.00
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	15.00	**25.00**	30.00	60.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
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: ZZZ Global Code

CPT Code:	61782	**Recommended Physician Work RVU: 3.18**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**0.00**	**15.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**25.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
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
20985	ZZZ	2.50	**RUC Time**

CPT Descriptor Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (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
		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:** 21.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 61782**	**Key Reference CPT Code: 20985**	**Source of Time RUC Time**
Median Pre-Service Time	15.00	10.00	
Median Intra-Service Time	25.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0 0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**40.00**	**30.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.60	2.53
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.93	2.80
Urgency of medical decision making	2.93	2.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.27	2.87
Physical effort required	2.20	2.27
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.20	2.60
Outcome depends on the skill and judgment of physician	3.60	3.13
Estimated risk of malpractice suit with poor outcome	3.07	2.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.53	2.53
Intra-Service intensity/complexity	3.07	3.00
Post-Service intensity/complexity	2.00	1.42

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background – Harvard & CPT

The Harvard study reviewed code 61795 for intra-time only, but appears to have been reviewed as the total procedure (not add-on) with a descriptor/vignette of "Stereotactic computer assisted volumetric intracranial procedure." The Harvard study total procedure intra-time is recorded as 239 minutes in the Harvard report. However, it appears that this

time was not used to value the procedure. In November 1998, the CMS time file created by a CMS contractor (required for the new methodology for computing resource-based practice expense RVUs) indicates 97 minutes (not 239) for code 61795. The "Time Source" in this file is "OTH" which corresponds to "Remaining services lacking time data were gap filled." Currently, the RUC database still indicates "CMS/Other" for the time of 97 minutes for this code. This information suggests that the current time assigned to code 61795 is an estimate made by CMS for practice expense purposes only.

Through CPT 1999, the descriptor for 61795 was "Stereotactic computer assisted volumetric intracranial procedure (list separately in addition to code for primary procedure)." However, as part of the development of a series of new codes to replace then current deep brain stimulation codes, an editorial change was made in 2000 to the long descriptor of 61795 to add *extracranial* and *spinal* procedures. The short descriptor was not changed and still reads *Brain surgery using computer.*

Background – Physician Fee Schedule

As the table below shows, the global period for 61795 has varied over time, but the work RVUs have not varied. The asterisked note in 1992 further indicates that CMS estimated work for 61795 and that it is not based on survey.

YEAR	CPT	RVW	GLOB	WORK SOURCE
1992	61795	4.25	ZZZ	2*
1993	61795	4.13	000	no rationale in Rule
1994	61795	4.08	000	
1995	61795	4.04	000	
1996	61795	4.04	000	
1997	61795	4.04	000	
1998	61795	4.04	000	
1999	61795	4.04	ZZZ	no rationale in Rule
2009	61795	4.03	ZZZ	

*2 = Physician work value established by HCFA. It may have been a refinement of a Harvard value, or a gap fill for a code for which Harvard did not provide a value. These include codes reviewed by carrier medical directors.

Background – RUC / CPT

In 2008, the RUC 5YR ID WG identified code 61795 through its screen of fastest growing procedures. The AANS/CNS, AAO-HNS, and NASS jointly noted that - *Growth seems to have been driven by use in endoscopic sinus surgery (#1 diagnosis code accounts for almost 1/3 of cases). This is just a broader application of this code and growth seems appropriate and does not indicate change in work. The increase in frequency in Otolaryngology is related to the increase in: 1)Providers being trained; 2)Number of possible revision cases; 3)Cases being identified that fit into the guidelines put forth by the AAO-HNS.* In 2002, the AAO-HNS endorsed the intraoperative use of computer-aided surgery in appropriately select cases to assist the surgeon in clarifying complex anatomy during sinus and skull base surgery. This was re-affirmed in 2005.

The changes in utilization, as shown below, correspond to the timing of the guidelines developed and published by AAO-HNS and the changes in the CPT descriptor to add extracranial and spinal procedures. We also note that it appears utilization has slowed considerably.

2000	2001	2002	2003	2004	2005	2006	2007	2008
6,821	5,938	8,132	10,481	13,032	14,738	17,181	18,122	18,384
	-13%	37%	29%	24%	13%	17%	5%	1%

Although the growth explanation was valid, the RUC 5YR ID WG requested survey of code 61795 because it had never been reviewed. Upon further discussion, the RUC and the specialties determined that the work (and technology) related to intracranial, extracranial, and spinal procedures may be different. A CPT proposal was submitted and the CPT EP approved deletion of 61795 and creation of three new codes to separate out cranial intradural, cranial extradural, and spinal.

Work RVU Recommendation

The joint specialty expert panel reviewing the survey data for 61782 believe the median RVW of 4.50 overstates the total work and intensity compared to a similar procedure and the reference code 20985.

To develop a recommendation, the joint specialty expert panel considered the differences in time to recently reviewed code 20985. New code 61782 includes 5 minutes of additional pre-time (5 x 0.0224 = 0.11) and 5 minutes of additional intra-time (5 x 0.114 = 0.57). We are **recommending an RVW of 3.18**, which accounts for these differences 2.50+0.11+1.14). This value is less than the survey median and correctly sets new code 61782 relative to the recently reviewed code 20985 which requires very similar work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Although this code will always be added to another primary procedure, there is no typical or dominant procedure that can be reported here.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 61795

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty otolaryngology How often? Commonly

Specialty neurosurgery 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. not able to estimate

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 8,273
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 45% of current code 61795 2008 Medicare frequency of 18,384

Specialty otolaryngology Frequency 7860 Percentage 95.00 %

Specialty neurosurgery Frequency 413 Percentage 4.99 %

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 63086

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:61783 Tracking Number P3 Specialty Society Recommended RVU: **3.75**
Global Period: ZZZ RUC Recommended RVU: **3.75**

CPT Descriptor: Stereotactic computer assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57-year-old male is diagnosed with a rupture of the transverse atlantal ligament. Operative stabilization of the C1-C2 segment is planned with computer-assisted image guided navigation for transarticular screw fixation and concomitant bone fusion.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

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Description of Pre-Service Work:
In addition to the standard discussion with the patient about the planned spinal procedure, the surgeon spends additional time discussing the use of stereotactic computer navigation as an adjunct to spinal surgery. This involves explaining the rationale for the use of the system, how it helps to confirm surgical position and avoid damage to surrounding vital structures, how it helps visualize instrument and implant position and that the surgery may be somewhat longer and more complicated. The explanation describes the placement of optical or electromagnetic tracking devices on the spine and key instruments and the identification of reference points.

Prior to the surgical procedure and positioning, the computer navigation unit is brought into the room and following booting up of the computer, the surgeon activates the navigation software and enters patient specific information such as identifiers, surgeon, site and side of surgery. Radiographic images that will be used for the navigation are either newly obtained or loaded from preexisting studies into the navigation computer. Setup options for the program are checked and adjusted as necessary. A detailed assessment of the image set in all three dimensions is performed by the surgeon on the computer workstation to analyze the surgical anatomy/pathology in relationship to surrounding anatomy. The final operative plan for the approach to and resection (if needed) of the disease process is completed.

Once the patient has been positioned on the operating table, the navigation unit is moved into place so the intra-operative trackers will be in the field of view of the cameras and the surgeon will be able to see the computer monitor screen.

Description of Intra-Service Work:
Once the spine has been exposed the required navigation trackers are secured to the spine and to key instruments. Tl trackers may be passive devices with reflective balls whose position is determined by infra-red light signals sent from the camera system which senses their position. They may also be active devices that emit infra-red light or electromagnetic signals that are sensed by a detection system. The initial part of the procedure is to register these trackers with the computer navigation system. Following activation and identification of the trackers, the registration process begins

Specific bony landmarks are identified individually by directed digitization with a "pointer" device that also has tracker components on it. Multiple reference points are identified and generally include one or more spinous process', facet joints, and transverse process'. After the anatomy has been registered, an assessment of the accuracy is confirmed with the pointing device. The position and angular alignment are checked at several sites. Changes to the trackers and reference points are made until accuracy within 1-2 millimeters is confirmed.

When placing spinal implants, typically screws, the navigation system is used to indentify the starting points for drill holes and the appropriate saggital and coronal alignment. Drill bit orientation and depth of penetration is checked frequently with periodic images as the drill is carefully and slowly advanced. Changes in alignment are made as necessary. Repeat navigation images are then obtained as the hole is tapped and again as the final screw or implant is inserted to ensure correct positioning. This entire sequence is then repeated for each screw or implant placed.

The navigation verification and subsequent correction of starting points and trajectory involve extra time and work. At the conclusion of the surgical procedure, the trackers are removed.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	John Wilson, MD; Edward Vates, MD; Alexander Mason, MD; Charles Mick, MD; William Sullivan, MD				
Specialty(s):	neurosurgery, spine surgery				
CPT Code:	61783				
Sample Size:	1707	**Resp N:**	64	**Response:** 3.7 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	5.00	**10.00**	25.00	180.00
Survey RVW:	2.00	3.00	**5.00**	6.50	9.15
Pre-Service Evaluation Time:			**30.00**		
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:	**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: ZZZ Global Code

CPT Code:	61783	**Recommended Physician Work RVU: 3.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**0.00**	**15.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	**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**
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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? 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
20985	ZZZ	2.50	**RUC Time**

CPT Descriptor Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (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
		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:** 28.1 **%**

TIME ESTIMATES (Median)	CPT Code: 61783	Key Reference CPT Code: 20985	Source of Time RUC Time
Median Pre-Service Time	15.00	10.00	
Median Intra-Service Time	30.00	20.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**45.00**	**30.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.94	2.59
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.83	2.59
Urgency of medical decision making	3.00	2.71
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.78	2.94
Physical effort required	2.56	2.29
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.56	2.88
Outcome depends on the skill and judgment of physician	3.78	3.18
stimated risk of malpractice suit with poor outcome	3.71	3.06

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.41	2.25
Intra-Service intensity/complexity	3.50	2.94
Post-Service intensity/complexity	1.69	1.73

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value `ecommendations for the appropriate formula and format.*

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The Harvard study reviewed code 61795 for intra-time only, but appears to have been reviewed as the total procedure (not add-on) with a descriptor/vignette of "Stereotactic computer assisted volumetric intracranial procedure." The Harvard study total procedure intra-time is recorded as 239 minutes in the Harvard report. However, it appears that this time was not used to value the procedure. In November 1998, the CMS time file created by a CMS contractor (require for the new methodology for computing resource-based practice expense RVUs) indicates 97 minutes (not 239) for code 61795. The "Time Source" in this file is "OTH" which corresponds to "Remaining services lacking time data were gap filled." Currently, the RUC database still indicates "CMS/Other" for the time of 97 minutes for this code. This information suggests that the current time assigned to code 61795 is an estimate made by CMS for practice expense purposes only.

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As the table below shows, the global period for 61795 has varied over time, but the work RVUs have not varied. The asterisked note in 1992 further indicates that CMS estimated work for 61795 and that it is not based on survey.

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1993	61795	4.13	000	no rationale in Rule
1994	61795	4.08	000	
1995	61795	4.04	000	
1996	61795	4.04	000	
1997	61795	4.04	000	
1998	61795	4.04	000	
1999	61795	4.04	ZZZ	no rationale in Rule
2009	61795	4.03	ZZZ	

*2 = Physician work value established by HCFA. It may have been a refinement of a Harvard value, or a gap fill for a code for which Harvard did not provide a value. These include codes reviewed by carrier medical directors.

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In 2008, the RUC 5YR ID WG identified code 61795 through its screen of fastest growing procedures. The AANS/CNS, AAO-HNS, and NASS jointly noted that - *Growth seems to have been driven by use in endoscopic sinus surgery (#1 diagnosis code accounts for almost 1/3 of cases). This is just a broader application of this code and growth seems appropriate and does not indicate change in work. The increase in frequency in Otolaryngology is related to the increase in: 1)Providers being trained; 2)Number of possible revision cases; 3)Cases being identified that fit into the guidelines put forth by the AAO-HNS.* In 2002, the AAO-HNS endorsed the intraoperative use of computer-aided surgery in appropriately select cases to assist the surgeon in clarifying complex anatomy during sinus and skull base surgery. This was re-affirmed in 2005.

The changes in utilization, as shown below, correspond to the timing of the guidelines developed and published by AAO-HNS and the changes in the CPT descriptor to add extracranial and spinal procedures. We also note that it appears utilization has slowed considerably.

2000	2001	2002	2003	2004	2005	2006	2007	2008
6,821	5,938	8,132	10,481	13,032	14,738	17,181	18,122	18,384
	-13%	37%	29%	24%	13%	17%	5%	1%

Although the growth explanation was valid, the RUC 5YR ID WG requested survey of code 61795 because it had neve been reviewed. Upon further discussion, the RUC and the specialties determined that the work (and technology) related to intracranial, extracranial, and spinal procedures may be different. A CPT proposal was submitted and the CPT EP approved deletion of 61795 and creation of three new codes to separate out cranial intradural, cranial extradural, and spinal.

Work RVU Recommendation

The joint specialty expert panel reviewing the survey data for 61783 believe the median RVW of 4.50 overstates the total work and intensity compared to a similar procedure and the reference code 20985. The joint specialty expert panel lso believes the survey respondents overestimated the pre-service time as this work is difficult to separate and estimate compared with the preservice work of the primary procedure. However, the expert panel does believe there is (conservatively) an additional 15 minutes of pre-service work, as described on the first page of this SoR.

To develop a recommendation, the joint specialty expert panel considered the differences in time to recently reviewed code 20985. New code 61783 includes 5 minutes of additional pre-time (5 x 0.0224 = 0.11) and 10 minutes of additional intra-time (10 x 0.114 = 1.14). We are **recommending an RVW of 3.75**, which accounts for these differences (2.50+0.11+1.14). This value is less than the survey median and correctly sets new code 61783 relative to the recently reviewed code 20985 which requires very similar work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Although this code will always be added to another primary procedure, there is no typical or dominant procedure that can be reported here.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 61795

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

pecialty 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. not able to estimate

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 919
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 5% of current code 61795 2008 Medicare frequency of 18,384

Specialty neurosurgery Frequency 460 Percentage 50.05 %

Specialty orthopaedic surgery Frequency 459 Percentage 49.94 %

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 61797 - intra-time and RVW are closer to recommendation

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 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

61781 Stereotactic computer assisted (navigational) procedure; **cranial-intradural** (List separately in addition to code for primary procedure)

61782 Stereotactic computer assisted (navigational) procedure; **cranial-extradural** (List separately in addition to code for primary procedure)

61783 Stereotactic computer assisted (navigational) procedure; **spinal** (List separately in addition to code for primary procedure)

Global Period ZZZ

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A joint specialty panel representing neurosurgery, otolaryngology, and spine surgery discussed the practice expense requirements for these three procedures and agree there are **no additional inputs**.

This is a facility only code.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

	A	B	C	D	E	F	G	H	I
1	AMA/Specialty Society RVS Update Committee Recommendation			P1		P2		P3	
2				61781		61782		61783	
3	**Meeting Date: February 2010**			Stereotactic computer assisted (navigational) procedure; cranial-intradural (List separately in addition to code for primary		Stereotactic computer assisted (navigational) procedure; cranial-extradural (List separately in addition to code for primary		Stereotactic computer assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)	
4	**LOCATION**	**Code**	**Staff Type**	**OFF**	**FAC**	**OFF**	**FAC**	**OFF**	**FAC**
5	**GLOBAL PERIOD**			**N/A**	**ZZZ**	**N/A**	**ZZZ**	**N/A**	**ZZZ**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**0**	**n/a**	**0**	**n/a**	**0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**0**	**n/a**	**0**	**n/a**	**0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**0**	**n/a**	**0**	**n/a**	**0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**0**	**n/a**	**0**	**n/a**	**0**
10	**PRE-SERVICE**								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA	**0**	**0**	**0**	**0**	**0**	**0**
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	**0**	**0**	**0**	**0**	**0**	**0**
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA	**0**	**0**	**0**	**0**	**0**	**0**
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**0**	**0**	**0**	**0**	**0**	**0**
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	**0**	**0**	**0**	**0**	**0**	**0**
17	Other Clinical Activity (please specify)	**L037D**	RN/LPN/MTA						
18	**End:When patient enters office/facility for surgery/procedure**								
19	**SERVICE PERIOD**								
20	**Start: When patient enters site for procedure: Services Prior to Procedure**								
39	Discharge day management	**L037D**	RN/LPN/MTA	**0**	**0**	**0**	**0**	**0**	**0**
41	**End: Patient leaves office**								
42	**POST-SERVICE Period**								
43	**Start: Patient leaves office/facility**								
44	Conduct phone calls/call in prescriptions								
45	*Office visits.*								
46	*List Number and Level of Office Visits*								
47	99211 16 minutes		16						
48	99212 27 minutes		27						
49	99213 36 minutes		36	**0**	**0**	**0**	**0**	**0**	**0**
50	99214 53 minutes		53						
51	99215 63 minutes		63						
52	Other								
53	***Total Office Visit Time***	**L037D**	**RN/LPN/MTA**	**0**	**0**	**0**	**0**	**0**	**0**
54	***Other Total:***								
55	**End: with last office visit before end of global period**								
56	**MEDICAL SUPPLIES**	**Code**	**Unit**						
57	pack, minimum multi-specialty visit	**SA048**	**pack**	**0**	**0**	**0**	**0**	**0**	**0**
58	pack, post-op incision care (suture & staple)	**SA053**	**pack**	**0**	**0**	**0**	**0**	**0**	**0**
59	**Equipment**	**Code**							
60	table, power	**EF031**		**0**	**0**	**0**	**0**	**0**	**0**
61	light, surgical	**EF014**		**0**	**0**	**0**	**0**	**0**	**0**

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five-Year Review – Site of Service Anomaly Screen

February 2010

Vagus Nerve Stimulator

In September 2007, CPT code 61885 was identified by the RUC through its Site of Service Anomaly Screen. After reviewing the vagal nerve stimulator family of services, the specialty societies agreed that the family lacked clarity and the CPT Editorial Panel, in October 2009, created three new codes to accurately describe revision of a vagal nerve stimulator lead, the placement of the pulse generator and replacement or revision of the vagus nerve electrode.

61885

1083

The RUC reviewed the survey results for code 61885 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array* and agreed that the survey data accurately reflects the specialties' selected pre-service time package (3- FAC Straightforward Patient/Difficult Procedure), intra time of 45 minutes and immediate post time of 20 minutes. However, the RUC agreed that the survey respondents overstated the physician work with a median of 7.00 RVUs.

The RUC compared the surveyed code to the key reference code 63685 *Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling* (Work RVU = 6.05 and intra time = 60 minutes) and found that the typical intra-service work between the two services is highly comparable even though the survey median intra-service time of is fifteen minutes lower than the intra-service time for the reference code. The specialty described that the difference is explained because the surveyed code has a higher percentage of neurosurgeons performing the service more efficiently than 63685, which is performed by a wide variety of specialties. Additionally, 61885 has a greater intensity of work because of the anatomic region, which has the potential for damage to the proximal electrodes during the procedure, and has greater total physician time of 181 minutes compared to 170 minutes.

The RUC also compared the surveyed code to other relative services. First the RUC compared 61885 to 49585 *Repair umbilical hernia, age 5 years or older; reducible* (Work RVU = 6.59, intra time = 45 minutes). This code has similar intra-service work and similar post operative physician work. Additionally, code 43888 *Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only* (Work RVU = 6.44, intra time = 45 minutes) was compared to the surveyed service and the RUC

agreed that this reference service, with an RVU of 6.44, properly approximates the intensity and complexity of 61885 and demonstrates appropriate relative work value amongst all physician services. **Therefore, based on the above comparisons, the RUC recommends 6.44 Work RVUs for 61885.**

64568

The RUC reviewed the survey results for code 64568 *Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator* and agreed that the survey data accurately reflects the specialties' selected pre-service time package (3- FAC Straightforward Patient/Difficult Procedure), intra time of 90 minutes and immediate post time of 30 minutes. However, the RUC agreed that the survey respondents overstated the physician work with a median of 12.00 RVUs.

The RUC compared the surveyed code to the key reference code 62223 *Creation of shunt; ventriculo-peritoneal, -pleural, other terminus* (Work RVU = 14.05, total time = 357 minutes). The committee agreed with the specialty that the reference service requires more total physician time and physician work compared to 64568. The RUC also reviewed the following codes in comparison to 64568: 63655 *Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural* (Work RVU = 11.56 and total time = 273 minutes), 26260 *Radical resection of tumor, proximal or middle phalanx of finger* (Work RVU = 11.16 and total time = 256 minutes) and 58660 *Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis)* (Work RVU = 11.59, total time = 209.5 minutes). The RUC came to a consensus that these services accurately portray similar physician intra-service work with analogous work intensity and complexity. A work RVU of 11.19, slightly lower than the median survey RVU, demonstrates appropriate relative value amongst all physician services. This service was previously reported with CPT code 61885 (2010 Work RVU = 7.57) and code 64573 (2010 Work RVU = 4.13 after multiple service reduction), resulting in a current work RVU of 11.70. Therefore, the RUC recommendation results in a reduction in total work RVUs. **The RUC recommends 11.19 Work RVUs for 64568.**

1084

64569

The RUC reviewed the survey results for code 64569 *Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator* and agreed that the survey data accurately reflects the physician time components involved in the procedure (pre-service time = 58 minutes, intra-service time = 120 minutes, immediate post service time = 30 minutes). The specialties selected pre-service time package 4- Difficult Patient/Difficult Procedure, subtracting 5 minutes from the scrub, dress and wait time because the survey respondents indicated a median pre-service time of 15 minutes for that component.

The RUC compared the surveyed code to the key reference code 63047 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda quine and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar* (Work RVU = 15.37 and total time = 362 minutes). The RUC found that while the reference code has 50 more minutes of total time, 64569 has 120 minutes intra-service time compared to 90 minutes for 63047. The median survey work RVU of 15.00 was chosen as it accurately aligns itself in relation to similar physician services. **The RUC recommends 15.00 Work RVUs for 64569.**

64570

The RUC reviewed the survey results for code 64570 *Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator* and agreed that the survey data accurately reflects the physician time components involved in the procedure (pre-service time = 58 minutes, intra-service time = 90 minutes, immediate post service time = 30 minutes). The specialties selected pre-service time package 4- Difficult Patient/Difficult Procedure, subtracting 5 minutes from the scrub, dress and wait time because the survey respondents indicated a median pre-service time of 15 minutes for that component.

The RUC compared the surveyed code to the key reference code 63047 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda quine and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar* (Work RVU = 15.37 and total time = 362 minutes). The RUC noted that while both services have 90 minutes of intra-service time, 63047 has significantly more total time due to a greater number of post operative visits, 362 minutes compared to 282 minutes for 64570. Given this gap in time and intensity, the median survey Work RVU of 13.00 was chosen as it accurately aligns itself in relation to similar physician services. **The RUC recommends 13.00 Work RVUs for 64570.**

1085

Practice Expense

The RUC reviewed the direct practice expense inputs and agreed that the 90 day global standard would apply and is recommended for these facility based services.

New Technology

The RUC recommends CPT codes 64569 and 64570 be placed on the RUC's new technology listing.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
61885	Q1	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	090	6.44
●64568	Q2	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator (Do not report 64568 in conjunction with 61885, 61886, 64570)	090	11.19
●64569	Q3	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator (For replacement of pulse generator see 61885) (Do not report 64569 in conjunction with 64570 or 61888)	090	15.00
●64570	Q4	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator (Do not report 64570 in conjunction with 61888)	090	13.00
D 64573		~~Incision for implantation of neurostimulator electrodes; cranial nerve~~ ~~(For open placement of cranial nerve (eg, vagal, trigeminal) neurostimulator pulse generator or receiver, see 61885, 61886 as appropriate)~~ ~~(For revision or removal of cranial nerve (eg, vagal, trigeminal) neurostimulator pulse generator or receiver, use 61888)~~ (64573 has been deleted)	090	N/A

1086

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:61885 Tracking Number Q1 Specialty Society Recommended RVU: **7.00**
Global Period: 090 RUC Recommended RVU: **6.44**

CPT Descriptor: Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male presents with essential tremor that has become quite severe and is disabling. He has had the disease for 8 years and has failed to obtain tremor relief using various oral medications and physical therapy. He is not a candidate for direct brain resection or an ablative brain procedure because of the severity of his tremor and the length of symptoms. His history also includes implantation of a deep brain stimulator electrode array, which upon stimulation, eliminated 80% of the patient's tremor. He undergoes internalization of the tail of the electrode array and placement and connection of a subcutaneous stimulator generator for long-term brain stimulation.

Percentage of Survey Respondents who found Vignette to be Typical: 70%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 68% , Kept overnight (less than 24 hours) 29% , Admitted (more than 24 hours) 3%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? 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

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Description of Pre-Service Work:
Review previous deep brain stimulation procedures; examining the tail of the stimulation electrode array for any disconnections or other technical problems (if this is a two-stage operation). Write pre-operative orders for peri-operative medications. Review planned incisions and procedure. Greet patient in holding area and update history and physical examination, review current medications, review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family. Sign and mark operative site. Obtain informed consent. Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite. Review length and type of anesthesia with anesthesiologist. Perform pre-procedural time-out confirming patient identity, surgical site, procedure, indicated perioperative medications, as necessary. Monitor initial patient positioning for induction of anesthesia. Monitor initial patient positioning for placement of neuro monitoring electrodes. Following the induction of anesthesia, assist with repositioning of patient. Verify/assist with padding of the patient to prevent pressure on neurovascular structures and placement of chin straps and arm traction devices to facilitate x-rays. Scrub and gown. Mark the incisions and supervise prepping/draping of the patient.

Description of Intra-Service Work:
Under general anesthesia, the cranial lead is recovered from the subgaleal space. A linear incision is made just below the clavicle over a distance of approximately 3 cm. A subcutaneous pocket is created under this incision. The cephalic wound is re-opened where the electrode array had been placed. A small incision is made at approximately the level of the mastoid and the electrode extension passer is passed from the cephalic wound down a subgaleal tract and out the mastoid woun Using this passer, the lead is pulled through the subcutaneous tract. The same passer is passed from the mastoid woun down another subcutaneous tract and out the clavicular wound, pulling the electrode tail and extension wire through this subcutaneous tract. A sleeve is placed on the distal tail of the electrode array. The array tail is inserted into the proximal end of the extension wire and tightened. The sleeve is placed over the connection and tied in place with 0-silk suture. The boot and connector are placed in the subgaleal space while the proximal end of the extension wire is secured to the skull. The distal end of the extension wire is inserted into the generator and tightened. Excess extension wire is coiled behind the stimulator generator. The stimulator generator is sutured into place in the subcutaneous tissue. The stimulator is tested, under sterile technique, to determine the impedance of the connections and rule-out and electrical short. The skin and subcutaneous tissues of all wounds are closed with deep sutures and skin staples.

Description of Post-Service Work:
Postoperative work includes application of sterile dressings; checking the entire stimulator system for proper function; communicating with the family and other health care professionals (including written and oral reports and orders); monitoring the patient's neurological condition for any defects; monitoring for infection; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient; review with the patient and family of post-discharge continuing care and instructions; and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of staples and sutures; monitoring wound healing; and examining the patient in the office at appropriate postoperative intervals to ensure adequate healing of all wounds and functioning/effectiveness of the stimulator system.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	John Wilson, MD; Edward Vates, MD; Alexander Mason, MD				
Specialty(s):	neurosurgery				
CPT Code:	61885				
Sample Size:	200	**Resp N:**	31	**Response:** 15.5 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**20.00**	44.00	120.00
Survey RVW:	5.00	6.05	**7.00**	10.00	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:	25.00	30.00	**45.00**	60.00	240 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):	**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: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	61885	**Recommended Physician Work RVU: 7.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**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:		**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):	**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? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
63685	090	6.05	**RUC Time**

CPT Descriptor Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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:** 48.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 61885**	**Key Reference CPT Code:** 63685	**Source of Time** **RUC Time**
Median Pre-Service Time	51.00	48.00	
Median Intra-Service Time	45.00	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	46.0	23.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**181.00**	**170.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	1.79	1.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.79	1.93
Urgency of medical decision making	2.36	1.71
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.14	2.29
Physical effort required	1.86	2.07
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	1.93	2.14
Outcome depends on the skill and judgment of physician	2.00	2.07
Estimated risk of malpractice suit with poor outcome	1.79	1.93

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.86	1.64
Intra-Service intensity/complexity	1.86	1.93
Post-Service intensity/complexity	1.93	1.86

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

61885

Background

The original RVW for 61885 was based on Harvard study intraoperative work estimates by four neurosurgeons and predicted pre- and post-operative work. Deep brain stimulation was not available in the 1980s during the Harvard study, nor were there any

indications approved for using more than one electrode array. Subsequent to the Harvard study, 61885 was reviewed during the first 5YR in 1995. Deep brain stimulation was not approved at the time of the 5YR and code 61855 was still not well understood or used.

In 1999, after approval of new technology and new indications and the ability to implant and connect to more than one electrode array, a series of new codes were approved to replace the existing deep brain stimulation codes. The changes also eliminated individual codes that emphasized minor differences in the type of skull opening used to place the electrode array. The revision to code 61885 (with connection to a single electrode array) and the creation of CPT code 61886 (with connection to two or more electrode arrays) were adopted to reflect changes in clinical practices. The RUC recommendation for 61885 in 1999 was 8.00 work RVUs. The key reference code was 63685 (1999 RVW = 7.04). This correctly aligned the difference in complexity between 63685 and 61885. However, CMS disagreed and maintained the RVW of 5.85 for 61885. Subsequent changes in code with a global period to reflect increases in EM services resulted in 2008 work RVUs of 7.37 for 61885 and 7.87 for 63685.

In 2008, code 63685 was identified by the RUC 5YR ID WG through a site of service screen. The global period for code 63685 was changed from 90-days to 10-days, the code was surveyed and the work RVUs were reduced to 6.00. Recent changes in the PFS to account for the elimination of consultation codes resulted in a slight increase in the work RVU for 63685 to 6.05.

Recommendation for 61185
CPT code 61885 was identified by the RUC 5YR ID WG through a site of service screen. The global period for this procedure remains 90-days. The AANS/CNS conducted a RUC survey and received 31 responses. The AANS/CNS believe the intra-work for 61885 is the same as 63685, with the only difference being the global period and one additional office visit for 61885. We recommend the survey median RVW of 7.00 (IWPUT=0.063). This value accounts for the additional 99213 office visit difference between 61885 and 63685. This is less than the current RVW and less than the previous RUC recommendation of 8.00.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 61885

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosugery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please xplain 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? 3,689
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2008 Medicare data for 61885 is 4358 and for 64573 is 669. When new code 645X0 is effective, some of the utilization for 61885 will be shifted (bundled) to 645X0.

Specialty neurosurgery Frequency 3100 Percentage 84.03 %

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? (ie. similar work RVU, and specialty) 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:64568 Tracking Number Q2 Specialty Society Recommended RVU: **11.75**
Global Period: 090 RUC Recommended RVU: **11.19**

CPT Descriptor: Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 31-year-old male with a 21-year history of partial complex epilepsy is experiencing 10 to 12 seizures per month and considerable side effects from maximal doses of carbamazepine and sodium valproate. His history includes previous single drug and poly pharmacy drug regimens, but in each case, the number, intensity, and duration of seizures were intolerable. His history also indicates no evidence for non-epileptic seizures under video EEG recording. He undergoes an open operation to implant a neurostimulator electrode and pulse generator on the vagus nerve.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 42% , Kept overnight (less than 24 hours) 48% , 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 93%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:
Review pre-operative lab work-up and images. Write pre-operative orders for peri-operative medications. Review planned incisions and procedure. Greet patient in holding area and update history and physical examination, review current medications, review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family. Sign and mark operative site. Obtain informed consent. Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite. Review length and type of anesthesia with anesthesiologist. Perform pre-procedural time-out confirming patient identity, surgical site, procedure, indicated perioperative medications, as necessary. Monitor initial patient positioning for induction of anesthesia. Monitor initial patient positioning for placement of neuro monitoring electrodes. Following the induction of anesthesia, assist with repositioning of patient. Verify/assist with padding of the patient to prevent pressure on neurovascular structures and placement of chin straps and arm traction devices to facilitate x-rays. Scrub and gown. Mark the incisions and supervise prepping/draping of the patient

Description of Intra-Service Work:
After induction of anesthesia, a curvilinear incision is made on the left side of the neck at the C5-6 level over the sternocleidomastoid muscle. The dissection is made to the plane between the subcutaneous fat and the platysma. The

subcutaneous fat is carefully dissected from the surface of the platysma and the wound edges are retracted with a self-retaining retractor. Hemostasis is obtained. An incision is made in the platysma and the sternocleidomastoid muscle is exposed. A dissection was made in the plane anterior to the sternocleidomastoid muscle. The sternocleidomastoid muscle is retracted laterally and the omohyoid muscle is mobilized and retracted inferiorly. The strap muscles are retracted medially. A dissection is made to the external jugular vein and the carotid sheath is exposed and carefully opened. The ansa cervicalis nerve is identified in the anterior carotid sheath and carefully retracted medially. A careful dissection is made between the carotid artery and the jugular vein. The superior thyroid vein and the superior thyroid artery are ligated and cut. The vagus nerve is exposed, being careful not to damage either the jugular vein, carotid artery, and laryngeal nerve. A dissection is carried out along the posterior carotid sheath and vagus nerve to expose about 6 cm of the nerve. Each of the three stimulator electrode coils are placed by coiling each individual electrode around the vagus nerve. A redundant loop of the electrode cable is placed a space created in the carotid sheath inferior to where the electrode coils are placed on the nerve. The cable is anchored to the tissue around the strap muscles with two silastic clips sutured to the fascia. The electrode array is tested for good contact with the nerve by measuring electrode impedance. The electrode array is repositioned, as necessary. The excess electrode cable is coiled in the space deep to the platysma and anchored with a silastic clip sutured to the sternocleidomastoid muscle fascia. Absolute hemostasis is obtained and the wound is irrigated with antibiotic solution. The electrode placement and efficacy are tested. The wound is inspected for any bleeding or damage to nerves, veins, and/or arteries. A new incision is made above the left axilla. A dissection is made in the subcutaneous tissue to create a pocket between the fat and the muscle fascia for the pulse generator. The tail of the electrode is tunneled subcutaneously using an electrode passer to permit connection to a neurostimulator pulse generator. The distal end of the electrode cable is inserted into the neurostimulator pulse generator and tightened. Excess electrode cable is coiled behind the neurostimulator pulse generator. The neurostimulator pulse generator is sutured into place in the pocket created in the subcutaneous tissue. The stimulator system is tested again, with sterile technique, to determine the impedance of the connections and rule-out an electrical short. The skin and subcutaneous tissues of all wounds are closed with deep sutures and skin staples.

Description of Post-Service Work:
Postoperative work includes application of sterile dressings; checking the entire stimulator system for proper function; communicating with the family and other health care professionals (including written and oral reports and orders); monitoring the patient's neurological condition for any deficits; monitoring for wound infection; and antibiotic and pain medication management. Frequently during the postoperative period, the patient's neurological condition is monitored for any deficits from either electrode placement and/or the stimulation itself and/or from carotid artery, jugular vein, or vagus nerve damage. Discharge day management includes the surgeon's final examination of the patient; review with the patient and family of post-discharge continuing care and instructions; and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of staples and sutures; monitoring wound healing; and examining the patient in the office at the appropriate postoperative intervals to ensure adequate healing of all wounds and functioning/effectiveness of the implant.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	John Wilson, MD; Alexander Mason, MD; Edward Vates, MD				
Specialty(s):	Neurosurgery				
CPT Code:	64568				
Sample Size:	200	**Resp N:**	31	**Response:** 15.5 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**10.00**	20.00	70.00
Survey RVW:	6.05	9.00	**12.00**	15.00	22.00
Pre-Service Evaluation Time:			**45.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	25.00	60.00	**90.00**	95.00	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):	**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: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	64568	**Recommended Physician Work RVU: 11.75**		
		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):	**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? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62223	090	14.05	**RUC Time**

CPT Descriptor Creation of shunt; ventriculo-peritoneal, -pleural, other terminus

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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:** 22.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 64568**	**Key Reference CPT Code:** 62223	**Source of Time** RUC Time
Median Pre-Service Time	51.00	90.00	
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	40.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	46.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**275.00**	**357.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.60	3.17
Urgency of medical decision making	3.33	3.20
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.80	2.83
Physical effort required	2.00	2.80
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.60	2.83
Outcome depends on the skill and judgment of physician	3.17	2.40
Estimated risk of malpractice suit with poor outcome	2.80	2.83

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.50	2.60
Intra-Service intensity/complexity	2.60	2.17
Post-Service intensity/complexity	3.00	2.60

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Background

CPT 64573 is a very old code, originally designed for an open incision and placement of a simple electrode on the trigeminal cranial nerve. The codes was originally created to complement the code for the very infrequently performed "percutaneous" placement of a neurostimulator electrode for trigeminal stimulation (64553). The original RVW for 64573 was based on the Harvard study from a response from three general surgeons, who estimated intra-service time at 37 minutes. The pre- and post-service work and time were

predicted. In the late 1990's, vagus cranial nerve stimulation was approved for seizure control. The vagal stimulator operation was not performed prior to that time.

Because CPT 64573, for a *generic* cranial nerve electrode placement was no longer required, AANS proposed to delete 64573 and create a new vagal nerve electrode placement descriptor. However, because of the decreasing availability of new CPT numbers, the CPT EP decided to re-use CPT 64573 for the new procedure. The new code for vagal nerve electrode placement became part of the review and survey for the deep brain stimulation codes in 1999.

In 2008, code 64573 was identified by the RUC 5YR ID WG through a site of service screen. After further consideration, the AANS/CNS proposed to bundle 64573 with 61885 to reflect current practice. We believe that the same surgeon will always place a pulse generator and implant the electrode for vagal nerve stimulation. The CPT EP agreed and approve deletion of code 64573 and creation of new code 64568 Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator.

Recommendation for 64568
The AANS/CNS conducted a RUC survey and received 31 responses. An RVW of 11.75 is recommended (IWPUT=0.069). This value is slightly less than the median and is equal to the multiple procedure billing of 64573 and 61885 (using the current recommendation of 7.00 for 61885). This value compares well with the key reference code 62223 (RVW=14.05) which requires the same intra-time, but one more hospital visit and one more office visit. For additional perspective, we offer two codes that require similar neck dissection 37605 and 60220 (MPC). The table below supports the recommendation for 64568.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	INTRA TIME	HV	OV
64568	*Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator*	***11.75***	*0.069*	*275*	*90*	*2*	*2*
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	**12.37**	0.077	275	90	2	2
37605	Ligation; internal or common carotid artery	**14.28**	0.071	342	90	3	2

We also note that vagal nerve stimulation is decreasing in frequency and is generally used for epilepsy. In recent years, vagal nerve stimulation has been used to treat depression. The Medicare data had gone from 1594 in 2006, to 952 in 2007 to 669 in 2008. It is estimated that national frequency has also declined significantly.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 61885 plus 64573

How often do physicians 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 How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 669
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2008 Medicare utilization of 64573

Specialty neurosurgery Frequency 370 Percentage 55.30 %

Specialty Frequency 0 Percentage 0.00 %

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. CPT Code 63664 Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluroscopy, when performed.

This code is more similar in terms of work relative values and time.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64569 Tracking Number Q3 Specialty Society Recommended RVU: **15.00**
Global Period: 090 RUC Recommended RVU: **15.00**

CPT Descriptor: Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 24-year-old male who has previous placement of a vagus nerve stimulator for intractable epilepsy with excellent results. While playing hockey, he is checked hard in his left shoulder resulting in breakage of the electrode. He undergoes an open operation to remove the previous electrode from the vagus nerve and placement of a new electrode array on the vagus nerve, with connection to the existing implanted pulse generator.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 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 34% , Kept overnight (less than 24 hours) 52% , 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 &M service later on the same day 93%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:
Write pre-operative orders for peri-operative medications. Review planned incisions and procedure. Greet patient in holding area and update history and physical examination, review current medications, review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family. Sign and mark operative site. Obtain informed consent. Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite. Review length and type of anesthesia with anesthesiologist. Perform pre-procedural time-out confirming patient identity, surgical site, procedure, indicated perioperative medications, as necessary. Monitor initial patient positioning for induction of anesthesia. Monitor initial patient positioning for placement of neuro monitoring electrodes. Following the induction of anesthesia, assist with repositioning of patient. Verify/assist with padding of the patient to prevent pressure on neurovascular structures and placement of chin straps and arm traction devices to facilitate x-rays. Scrub and gown. Mark the incisions and supervise prepping/draping of the patient.

Description of Intra-Service Work:
After induction of anesthesia, a curvilinear incision is made on the left side of the neck at the C5-6 level in the scar from the previous surgery over the sternocleidomastoid muscle. The wound edges are retracted with a self-retaining retractor. Hemostasis is obtained. The old electrode cable is identified in the subcutaneous space. This old electrode is followed

with meticulous dissection through the scar tissue to the point where it penetrates the platysma and enters the space anterior to the sternocleidomastoid muscle. A dissection is made in the scar tissue anterior to the sternocleidomastoid muscle and this muscle is retracted laterally. The omohyoid muscle is dissected from the scar tissue and mobilized and retracted inferiorly. The strap muscles are retracted medially. A dissection is made following the old electrode cable into the scar tissue surrounding the external jugular vein and the carotid sheath. The scar tissue in the carotid sheath is dissected ar opened. The ansa cervicalis nerve is identified in the scar tissue of the anterior carotid sheath and retracted medially. A dissection is made following the electrode cable into the dense adhesions between the carotid artery and the jugular vein. The vagus nerve is dissected from the surrounding scar tissue and adhesions and exposed, being careful not to damage either the jugular vein, carotid artery, and laryngeal nerve. The old electrode cable is cut, leaving the three helical coils still attached to the vagus nerve. Each one of these helical coils is then in turn very carefully dissected from the scar tissue and adhesions around the vagus nerve. The new electrode array is then placed in the wound. Each of the three stimulator electrode coils are placed by coiling each individual electrode around the vagus nerve. The electrode array is tested for good contact with the nerve by measuring electrode impedance. The electrode array is repositioned, as necessary. A redundant loop of the electrode cable is placed a space created in the carotid sheath inferior to where the electrode coils are placed on the nerve. The cable is anchored to the tissue around the strap muscles with two silastic clips sutured to the fascia. The electrode array is tested for good contact with the nerve by measuring electrode impedance. The electrode array is repositioned, as necessary. The excess electrode cable is coiled in the space deep to the platysma and anchored with a silastic clip sutured to the sternocleidomastoid muscle fascia. Absolute hemostasis is obtained and the wound is irrigated with antibiotic solution. The electrode placement and efficacy are tested. The wound is inspected for any bleeding or damage to nerves, veins, and/or arteries. The old incision above the left axilla is opened with sharp dissection.. A dissection is made in the scar tissue in the subcutaneous tissue to the neurostimulator pulse generator. The old electrode cable is identified in the scar tissue and removed. The electrode cable is disconnected from the neurostimulator pulse generator. The tail of the new electrode cable is tunneled subcutaneously using an electrode passer. The distal end of the electrode cable is inserted into the neurostimulator pulse generator and tightened. Excess electrode cable is coiled behind the neurostimulator pulse generator. The neurostimulator pulse generator is sutured into place in the pocket created in the subcutaneous tissue. The stimulator system is tested again, utilizing sterile technique, to determine the impedance of the connections and rule-out an electrical short. The skin and subcutaneous tissues of all wounds are closed with deep sutures and skin staples.

Description of Post-Service Work:
Postoperative work includes application of sterile dressings; checking the entire stimulator system for proper function; communicating with the family and other health care professionals (including written and oral reports and orders); monitoring the patient's neurological condition for any deficits; monitoring for wound infection; monitor for post-anesthesia nausea or seizures, antibiotics and pain medication management. Frequently during the postoperative period, the patient's neurological condition is monitored for any deficits from either electrode placement and/or the stimulation itself and/or from carotid artery, jugular vein, or vagus nerve damage. Discharge day management includes the surgeon's final examination of the patient; review with the patient and family of post-discharge continuing care and instructions; and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of staples and sutures; monitoring wound healing; and examining the patient in the office at the appropriate postoperative intervals to ensure adequate healing of all wounds and functioning/effectiveness of the implant.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010					
Presenter(s):	John Wilson, MD; Alexander Mason, MD; Edward Vates, MD					
Specialty(s):	neurosurgery					
CPT Code:	64569					
Sample Size:	200	**Resp N:**	31	**Response:** 15.5 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	3.00	5.00
Survey RVW:	6.05	11.00	**15.00**	15.69	22.00
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	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):	**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):	**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:	64569	**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:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
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):	**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? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
63047	090	15.37	**RUC Time**

CPT Descriptor 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

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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:** 35.4 **%**

TIME ESTIMATES (Median)	**CPT Code: 64569**	**Key Reference CPT Code:** 63047	**Source of Time** **RUC Time**
Median Pre-Service Time	58.00	95.00	
Median Intra-Service Time	120.00	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	40.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	46.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**312.00**	**362.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.60	4.18
Urgency of medical decision making	3.00	3.40
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.70	3.00
Physical effort required	2.64	3.10
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.40	3.27
Outcome depends on the skill and judgment of physician	4.00	2.70
stimated risk of malpractice suit with poor outcome	2.90	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	2.60	2.55
Post-Service intensity/complexity	4.18	2.60

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 ecommendations for the appropriate formula and format.*

PT code 64569 is a new code to describe the work for a revision or replacement of a vagal nerve stimulator electrode array, with connection to a pulse generator. The revision work is more intense and requires additional intra-operative time compare with the work of implanting a vagal nerve stimulator electrode array for the first time. Previously, there was no code to report this rarely performed service. Because of low frequency and experience, an unlisted code was used. However, over time, some implanted electrodes broke (eg,

trauma per vignette), requiring removal of the old electrode and replacement of a new electrode with connection to a pulse generator. This requires delicate dissection of a scarred-in electrode that is coiled around the vagus nerve prior to placing a new electrode.

The AANS/CNS conducted a RUC survey and received 31 responses. The median RVW of 15.00 is recommended (IWPUT=0.077). This value is slightly less than the key reference and MPC code 63047 which has 30 minutes less intra-time, but additional post-op work (higher level hospital visit and one additional office visit). This recommendation also compares well with th recommendation for 645X0 placing a virgin electrode and pulse generator – accounting for the additional intra-operative time, intensity and complexity.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in you scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64999 Unlisted procedure, nervous system

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency not available

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 75 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. committee consensus

'pecialty neurosurgery	Frequency 75	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? (ie. similar work RVU, and specialty) 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:64570 Tracking Number Q4 Specialty Society Recommended RVU: **13.00**
Global Period: 090 RUC Recommended RVU: **13.00**

CPT Descriptor: Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 23-year-old male with a previously placed vagus nerve stimulator electrode array and pulse generator presents with erosion of the wire through the skin and infection of the hardware. He undergoes an open operation to remove the vagus nerve stimulator electrode array and pulse generator.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 39% , Kept overnight (less than 24 hours) 32% , 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 90%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:
Write pre-operative orders for peri-operative medications. Review planned incisions and procedure. Greet patient in holding area and update history and physical examination, review current medications, review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family. Sign and mark operative site. Obtain informed consent. Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite. Review length and type of anesthesia with anesthesiologist. Perform pre-procedural time-out confirming patient identity, surgical site, procedure, indicated perioperative medications, as necessary. Monitor initial patient positioning for induction of anesthesia. Monitor initial patient positioning for placement of neuro monitoring electrodes. Following the induction of anesthesia, assist with repositioning of patient. Verify/assist with padding of the patient to prevent pressure on neurovascular structures and placement of chin straps and arm traction devices to facilitate x-rays. Scrub and gown. Mark the incisions and supervise prepping/draping of the patient.

Description of Intra-Service Work:
After induction of anesthesia, a curvilinear incision is made on the left side of the neck at the C5-6 level in the scar fro the previous surgery over the sternocleidomastoid muscle. Pus is encountered upon opening and cultures are taken and the wound irrigated copiously with antibiotic solution. The wound edges are retracted with a self-retaining retractor. Hemostasis is obtained. The old electrode cable is identified in the subcutaneous space. This old electrode is followed with meticulous dissection through the scar tissue to the point where it penetrates the platysma and enters the space anterior

to the sternocleidomastoid muscle. A dissection is made in the scar tissue anterior to the sternocleidomastoid muscle and this muscle is retracted laterally. The omohyoid muscle is dissected from the scar tissue and mobilized and retracted inferiorly. The strap muscles are retracted medially. A dissection is made following the old electrode cable into the scar tissue surrounding the external jugular vein and the carotid sheath. The scar tissue in the carotid sheath is dissected and opened. The ansa cervicalis nerve is identified in the scar tissue of the anterior carotid sheath and retracted medially. A dissection is made following the electrode cable into the dense adhesions between the carotid artery and the jugular vein. The vagus nerve is dissected from the surrounding scar tissue and adhesions and exposed, being careful not to damage either the jugular vein, carotid artery, and laryngeal nerve. The old electrode cable is cut and the cable and anchoring clips are removed, leaving the three helical coils still attached to the vagus nerve. The old electrode cable and anchoring clips are sent to the laboratory for culture and sensitivity. Each one of these helical coils is then in turn very carefully dissected from the scar tissue and adhesions around the vagus nerve. These coils are then sent to the laboratory for culture and sensitivity. Absolute hemostasis is obtained and the wound is irrigated with large amounts of antibiotic solution. The wound is inspected for any bleeding or damage to nerves, veins, and/or arteries. The old incision above the left axilla is opened with sharp dissection.. There is, again, pus around the generator within the subcutaneous pocket. This is cultured and evacuated. A dissection is made in the scar tissue in the subcutaneous tissue to the neurostimulator pulse generator. The old electrode cable and neurostimulator pulse generator are identified in the scar tissue and removed. This hardware is sent to the laboratory for culture and sensitivity. A closed suction drain is placed and exited through a separate stab incision. It is sutured into place. The wound is irrigated with large amounts of antibiotic solution The skin and subcutaneous tissues of all wounds are closed with deep sutures and skin staples.

Description of Post-Service Work:
Postoperative work includes application of sterile dressings; checking the closed suction drainage system for proper function; communicating with the family and other health care professionals (including written and oral reports and orders); monitoring the patient's neurological condition for any deficits; monitoring for wound infection; and antibiotic and pain medication management. Frequently during the postoperative period, the patient's neurological condition is monitored for any deficits from either electrode removal and/or from carotid artery, jugular vein, or vagus nerve damage. Once cultures are back and appropriate antibiotics determined, home intravenous antibiotic therapy is set up. A PICC line is placed by the IV team. Discharge day management includes the surgeon's final examination of the patient; review with the patient and family of post-discharge continuing care and instructions; and preparation of discharge records. The external drain is removed prior to discharge. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure; including removal of staples and sutures; monitoring the reports of growth of bacterial cultures; changing post-operative antibiotics as appropriate to the sensitivities of the cultured bacteria; monitoring wound healing; and examining the patient in the office at the appropriate postoperative intervals to ensure adequate healing of all wounds.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	John Wilson, MD; Edward Vates, MD, Alexander Mason, MD				
Specialty(s):	neurosurgery				
CPT Code:	64570				
Sample Size:	200	**Resp N:**	31	**Response:**	15.5 %
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	2.00	3.00
Survey RVW:	5.00	9.10	**13.00**	15.00	30.00
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	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):	**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:	64570	**Recommended Physician Work RVU: 13.00**		
		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:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**90.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**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):	**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? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
63047	090	15.37	**RUC Time**

CPT Descriptor 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

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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:** 25.8 **%**

TIME ESTIMATES (Median)	CPT Code: 64570	Key Reference CPT Code: 63047	Source of Time RUC Time
Median Pre-Service Time	58.00	95.00	
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	40.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	46.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**282.00**	**362.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.43	3.75
Urgency of medical decision making	2.88	3.14
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.17	2.63
Physical effort required	3.13	2.71
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.14	2.88
Outcome depends on the skill and judgment of physician	3.63	2.29
Estimated risk of malpractice suit with poor outcome	2.71	3.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.75	2.57
Intra-Service intensity/complexity	2.43	3.00
Post-Service intensity/complexity	4.13	2.14

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT code 64570 is a new code to describe the work for removing a vagal nerve stimulator electrode array and pulse generator. The removal of a previously placed electrode that is scarred-in and coiled around the vagal nerve requires delicate dissection compared with the work of implanting a vagal nerve stimulator electrode array for the first time. Previously, there was no code to report this rarely performed service. Because of low frequency and experience, an unlisted code was used. However, over time, removal of electrodes and pulse generators because of infection and/or failure was necessary.

The AANS/CNS conducted a RUC survey and received 31 responses. The median RVW of 13.00 is recommended (IWPUT=0.081). This value is appropriate less than the key reference and MPC code 63047 which requires additional post-op work (higher level hospital visit and one additional office visit). This recommendation also compares well with the recommendation for 64568 placing a virgin electrode and pulse generator (accounting for the additional intra-operative intensity and complexity) and with 64569 (accounting for the difference in intra-operative 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) 64999 Unlisted procedure, nervous system

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 40 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. committee consensus

Specialty neurosurgery	Frequency 40	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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 61535

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, 010, or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

Track	CPT	Descriptor
Q1	61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
Q2	64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator
Q3	64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator
Q4	64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator

Global Period 090

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A joint specialty panel representing neurosurgery, orthopaedic surgery, and spine surgery discussed the practice expense requirements for these four codes and determined that the standard 90-day global inputs would apply.

These are facility-only codes.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre-service diagnostic & referral forms are completed. Pre-surgery clearance is arranged and verified. The operation and equipment/supplies necessary are scheduled. Talk with the patient and family about pre-, and post-operative expectations and possible complications. Explain the operation to the patient and family. Review informed consent. Contact the patient prior to surgery to verify prescribed changes in medications and pre-operative cleansing and diet. The standard 60 minutes for 90-day global procedures has been applied.

Intra-Service Clinical Labor Activities:

Clinical staff communicates with the facility staff, patient's family, insurance staff, and PCP/referring physician regarding discharge instructions and follow-up requirements. The standard 6-minutes for same day discharge and 12-minutes for inpatient discharge has been applied.

Post-Service Clinical Labor Activities:

Standard times to ready patient/records and assist physician at each post-op office visit have been applied.

	A	B		D	E	F	G	H	I	J	K
1	AMA/Specialty Society RVS Update Committee Recommendation			Q1		Q2		Q3		Q4	
2				61885		64568		64569		64570	
3	**Meeting Date: February 2010**			Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array		Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator		Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator		Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	
4	**LOCATION**	**Code**	**Staff Type**	**OFF**	**FAC**	**OFF**	**FAC**	**OFF**	**FAC**	**OFF**	**FAC**
5	**GLOBAL PERIOD**			**90**	**90**	**90**	**90**	**90**	**90**	**90**	**90**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**138**	**n/a**	**144**	**n/a**	**144**	**n/a**	**144**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**60**	**n/a**	**60**	**n/a**	**60**	**n/a**	**60**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**6**	**n/a**	**12**	**n/a**	**12**	**n/a**	**12**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**72**	**n/a**	**72**	**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	**0**	**5**	**0**	**5**	**0**	**5**	**0**	**5**
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	**0**	**20**	**0**	**20**	**0**	**20**	**0**	**20**
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA	**0**	**8**	**0**	**8**	**0**	**8**	**0**	**8**
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**0**	**20**	**0**	**20**	**0**	**20**	**0**	**20**
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	**0**	**7**	**0**	**7**	**0**	**7**	**0**	**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	**0**	**6**	**0**	**12**	**0**	**12**	**0**	**12**
41	**End: Patient leaves office**										
42	**POST-SERVICE Period**										
43	**Start: Patient leaves office/facility**										
44	Conduct phone calls/call in prescriptions										
45	*Office visits*										
46	*List Number and Level of Office Visits*										
47	99211 16 minutes		16								
48	99212 27 minutes		27								
49	99213 36 minutes		36	**0**	**2**	**0**	**2**	**0**	**2**	**0**	**2**
50	99214 53 minutes		53								
51	99215 63 minutes		63								
52	Other										
53	***Total Office Visit Time***	**L037D**	**RN/LPN/MTA**	**0**	**72**	**0**	**72**	**0**	**72**	**0**	**72**
54	***Other Total:***										
55	**End: with last office visit before end of global period**										
56	**MEDICAL SUPPLIES**	**Code**	**Unit**								
57	pack, minimum multi-specialty visit	**SA048**	**pack**	**0**	**2**	**0**	**2**	**0**	**2**	**0**	**2**
58	pack, post-op incision care (suture & staple)	**SA053**	**pack**	**0**	**1**	**0**	**1**	**0**	**1**	**0**	**1**
59	**Equipment**	**Code**									
60	table, power	**EF031**		**0**	**72**	**0**	**72**	**0**	**72**	**0**	**72**
61	light, surgical	**EF014**		**0**	**72**	**0**	**72**	**0**	**72**	**0**	**72**

AMA/Specialty Society RVS Update RUC
Summary of Recommendations

Originated from Five-Year Review – CMS Fastest Growing Screen

October 2009

Transforaminal Epidural Injections

CPT codes 64479, 64480, 64483 and 64484 were identified in October 2008 along with other services in its family, paravertebral facet joint codes (currently 64490-64495) through CMS' Fastest Growing Screen. The RUC recommended that these four services along with the other codes in its family be referred to the CPT Editorial Panel to be bundled with the appropriate guidance procedure(s). In June 2009, the CPT Editorial Panel revised codes 64479, 64480, 64483 and 64484 to include guidance (fluoroscopy or CT).

1119

64479 - Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

The specialty society conducted a survey in which 139 physicians responded. The RUC reviewed the pre-service time package selected for code 64479 (2a-Facility Diff Pat/Straightforward Procedure) and determined to appropriately value this service the pre-service time package should be 1A-FAC Straightforward Patient/Straightforward Procedure (13 minutes evaluation, 1 minute positioning and 6 minutes scrub/dress/wait). The RUC agreed with the specialty societies that 4 minutes additional positioning time is necessary to place the patient in the prone position. Additionally, the specialty societies recommended and the RUC agreed that the immediate post-service time should be reduced from 15 minutes to 10 minutes, to be consistent with the facet family of codes (64490 and 64493) which were reviewed at the April 2009 RUC meeting.

The RUC compared 64479 to the key reference service 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) and determined that 64479 was more complex and intense. The RUC also compared this service to similar service 52000 *Cystourethroscopy (separate procedure)* (pre-time 17 minutes, intra-time 15 minutes, and immediate post-time 10 minutes and a work RVU = 2.23) which requires similar physician time and work to perform.

The RUC agreed that a work RVU of 2.29 for 64479 was appropriate compared to the aforementioned reference services and due to the decrease in pre- and post-service times. The value is between the 25% and median survey results. Additionally, the RUC noted that 64479 was appropriately more intense than 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* (April 2009 RUC recommended work RVU = 1.82 and 17 minutes pre-time, 15 minutes intra-time and 10 minutes immediate post-service time). **The RUC recommends a work RVU of 2.29 for code 64479 and 13 minutes pre-evaluation time, 5 minutes pre-positioning time, 6 minutes scrub/dress/wait time, 15 minutes intra-service time and 10 minutes immediate post-service time.**

64480 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), cervical or thoracic; each additional level

The specialty society conducted a survey in which 115 physicians responded. The RUC reviewed the specialty society recommendation for code 64480 comparing it to base code 64479 and determined that the survey 25th percentile work RVU of 1.20 and 15 minutes intra-service time preserves rank order within this family of services. The RUC compared 64480 to similar ZZZ codes 15136 *Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof* (work RVU = 1.50 and 15 minutes intra-service time) and 61517 *Implantation of brain intracavitary chemotherapy agent* (work RVU = 1.38 and 15 minutes intra-service time) to further support the recommended value of 1.20 work RVUs for 64480.

1120

The RUC also compared code 64480 to the April 2009 RUC recommended similar service 64491 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level* (RUC recommended work RVU = 1.16 and 15 minutes intra-service time) to further support the recommended work RVU of 1.20 for 64480. **The RUC recommends the survey 25th percentile work RVU of 1.20 for code 64480.**

64483 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), lumbar or sacral; single level

The specialty society conducted a survey in which 145 physicians responded. The RUC reviewed the pre-service time package selected for code 64483 (2a-Facility Diff Pat/Straightforward Procedure) and determined to appropriately value this service the pre-service time package should be 1A-FAC Straightforward Patient /Straightforward Patient (13 minutes evaluation, 1 minute positioning and 6 minutes scrub/dress/wait). The RUC agreed with the specialty societies that 4 additional minutes of positioning time is necessary to place the patient in the prone position.

The RUC compared 64483 to MPC service 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90 and pre-time 25 minutes, intra-time 15 minutes and post-time 5 minutes) which requires similar physician time and work to perform, supports a work RVU of 1.90 for code 64483.

Additionally, the RUC noted that a work RVU of 1.90 for 64483 was appropriately more intense than 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* (April 2009 RUC recommended work RVU = 1.52 and 17 minutes pre-time, 15 minutes intra-time and 10 minutes immediate post-service time). **The RUC recommends a work RVU of 1.90 for code 64483 and 13 minutes pre-evaluation time, 5 minutes pre-positioning time, 6 minutes scrub/dress/wait time, 15 minutes intra-service time and 10 minutes immediate post-service time.**

64484 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), lumbar or sacral; lumbar or sacral, each additional level

The RUC reviewed the specialty society recommendation for code 64484 comparing it to base code 64483 and determined that the survey 25th percentile work RVU of 1.00 and 10 minutes intra-service time preserves rank order within this family of services. The RUC compared 64484 to similar ZZZ codes 15331 *Acellular dermal allograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof* (work RVU = 1.00 and 13 minutes intra-service time) and 76802 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation* (work RVU = 0.83 and 10 minutes intra-service time) to further support the recommended value of 1.00 work RVUs for 64484.

1121

The RUC also compared code 64484 to the April 2009 RUC recommended similar service 64494 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT) lumbar or sacral; second level* (RUC recommended work RVU = 1.00 and 15 minutes intra-service time) to further support the recommended work RVU of 1.00 for 64484. **The RUC recommends the survey 25th percentile work RVU of 1.00 for code 64484.**

Practice Expense

The RUC reviewed the clinical labor time and made minor adjustments to reflect the typical patient scenario. In addition, the RUC reviewed the medical supplies and equipment and added a pulse oximeter. The RUC determined to include the fluoroscopic radiographic room until the Practice Expense Subcommittee's Fluoroscopic Workgroup develops final recommendations regarding this issue.

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. Approximately 50% of 64479 and 50% of 64483 will be no longer be reported under 77003 now that 64479 and 64483 include image guidance.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●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 ~~joint~~ level	000	1.82 (April 2009 RUC recommendation)
● +64491		second level (List separately in addition to code for primary procedure)	ZZZ	1.16 (April 2009 RUC recommendation)
● +64492		third and any additional level(s) ~~level or more facet joints~~ (List separately in addition to code for primary procedure) *(Do not report 64492 more than once per day)* *(Use 64491, 64492 in conjunction with 64490)*	ZZZ	1.16 (April 2009 RUC recommendation)
●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 ~~joint~~ level	000	1.52 (April 2009 RUC recommendation)
●+64494		second level (List separately in addition to code for primary procedure)	ZZZ	1.00 (April 2009 RUC recommendation)

1122

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●64495		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, 64495 in conjunction with 64493)*	ZZZ	1.00 (April 2009 RUC recommendation)
▲64479	B1	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level (For transforaminal epidural injection under ultrasound guidance, use 0228T)	000	2.29
▲+64480	B2	cervical or thoracic, each additional level (List separately in addition to code for primary procedure) *(Use 64480 in conjunction with 64479)* *(For transforaminal epidural injection under ultrasound guidance, use 0229T)* *(For transforaminal epidural injection at the T12-L1 level, report 64483use 64479)*	ZZZ	1.20
▲64483	B3	lumbar or sacral, single level (For transforaminal epidural injection under ultrasound guidance, use 0230T)	000	1.90

1123

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲ +64484	B4	lumbar or sacral, each additional level (List separately in addition to code for primary procedure) (For transforaminal epidural injection under ultrasound guidance, use 0231T) (Codes 64479-64484 are unilateral procedures. For bilateral procedures, use modifier 50) *(Use 64484 in conjunction with 64483)*	ZZZ	1.00
76942		Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation (Do not report 76942 in conjunction with 37760, 37761, 43232, 43237, 43242, 45341, 45342, ~~or~~64479-64484, 64490-64495, 76975, 0228T-0231T, 0232T, 0249T) (For injection(s) of platelet rich plasma, use 0232T)	XXX	0.67 (No Change)
▲77003		Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, ~~transforaminal epidural,~~ subarachnoid, or sacroiliac joint), including neurolytic agent destruction	XXX	0.60 (No Change)

1124

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(For sacroiliac joint arthrography, see 27096, ... (For paravertebral facet joint injection, see 64490-64495. For transforaminal epidural needle placement and injection, see 64479-64484) (Do not report 77003 in conjunction with 64479–64484, 64490-64495)		
77012		Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation (Do not report 77012 in conjunction with 64479-64484, 64490-64495, 0232T) (For injection(s) of platelet rich plasma, use 0232T)	XXX	1.16 (No Change)

1125

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64479 Tracking Number B1 Specialty Society Recommended RVU: **2.50**
Global Period: 000 RUC Recommended RVU: **2.29**

CPT Descriptor: Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male presents with constant, moderately severe, right arm pain that limits all activity. The patient's history includes a previous laminectomy at C5-6; and MRI with gadolinium, showing a small bony spur at the right C5-6 foramen compressing the C6 nerve root; and neurodiagnostic studies compatible with C6 radiculopathy. He has failed to obtain relief using various oral medications, physical therapy, and traction. He undergoes a transforaminal epidural injection of an anesthetic agent and/or steroid at the C5-6 level.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 58%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 36%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Pre-service work includes review of records and any pertinent imaging studies; communicating with other professionals, patient, and family; and obtaining consent. The pre-service work also includes dressing, scrubbing, and waiting before the procedure, preparing the patient and needed equipment for the procedure, positioning the patient in the prone position on the x-ray table for appropriate fluoroscopic view, and draping of the injection site.

Description of Intra-Service Work: The affected foramen is identified and the skin is infiltrated with local anesthetic. A needle is directed lateral to midline under fluoroscopic guidance into the foramen. Both AP and oblique views are needed to get depth as well as anterior and posterior position. Contrast injection is performed to confirm needle tip location. Once this is completed anesthetic agent and/or steroid is injected. The injection needle is removed and dressing applied.

Description of Post-Service Work: After the procedure, the patient is taken to the recovery area and observed for any new and unexpected neurological deficits. The physician reviews the procedure and results with the patient and other professionals. The physician evaluates the patient's neurologic condition prior to discharge from the recovery area.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2009		
Presenter(s):	Marc Leib, MD, JD, Richard Rosenquist, MD, Charles Mick, MD, Rodney Lee Jones, MD, Fred Davis, MD, William Sullivan, MD, Sean Tutton, MD, William Donovan, MD		
Specialty(s):	ASA, NASS, ISIS, AAPM, AAPMR, SIR, ASNR		
CPT Code:	64479		
Sample Size:	1185	**Resp N:** 139	**Response:** 11.7 %
Sample Type:	Panel **Additional Sample Information:** Survey respondents represent a pool of physicians who responded to a website notice soliciting physicians willing to complete these surveys and also physicians who had completed previous surveys.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**30.00**	100.00	2000.00
Survey RVW:	0.60	2.00	**2.50**	2.95	10.00
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	5.00	10.00	**15.00**	20.00	45.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1a-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64479	**Recommended Physician Work RVU: 2.29**		
		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:		**5.00**	**1.00**	**4.00**
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
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
51102	000	2.70	**RUC Time**	14,289

CPT Descriptor 1 Aspiration of bladder; with insertion of suprapubic catheter

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52000	000	2.23	**RUC Time**	948,337

CPT Descriptor 2 Cystourethroscopy (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: 72 **% of respondents:** 51.7 %

TIME ESTIMATES (Median)	**CPT Code: 64479**	**Key Reference CPT Code: 62310**	**Source of Time RUC Time**
Median Pre-Service Time	24.00	35.00	
Median Intra-Service Time	15.00	30.00	
Median Immediate Post-service Time	10.00	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	**49.00**	**85.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.74	3.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.85	3.64
Urgency of medical decision making	3.36	3.26
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.71	4.18
Physical effort required	3.56	3.36
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.75	4.14
Outcome depends on the skill and judgment of physician	4.69	4.24
Estimated risk of malpractice suit with poor outcome	4.75	4.35

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.42	3.32
Intra-Service intensity/complexity	4.37	3.97
Post-Service intensity/complexity	3.15	3.06

Additional Rationale and Comments

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 Recommendations for the appropriate formula and format.*

This family of codes was flagged for review by the RUC's Five Year Review Identification Workgroup because of fast rate of growth. The codes were referred to CPT and the CPT Editorial Panel approved a request to revise the descriptors to

make it clear that imaging guidance (fluoro or CT) was a required element of the service. Per the revised descriptors, that guidance is now to be included in the valuation assigned to the procedures and will no longer be separately reportable.

We recommend pre-service package 1A with modification to the positioning time because the patient is prone and to the scrub/dress/wait time because the procedure is performed under sterile conditions.

The specialties are recommending the survey median of 2.50 work RVUs for code 64479. While the times are indeed lower than those of the reference service, the risk and complexity of a transforaminal epidural injection is higher than that associated with an interlaminar epidural. To perform a transforaminal epidural injection, the physician inserts a needle via the extremely small aperture (size of a small shirt button hole) in the spinal canal through which the nerve root exits on its way to the extremities. The task is to place the needle in that aperture next to that nerve root without injuring either the nerve root or the blood vessels in close proximity, or without entering too far and breaching the dura, thereby inadvertently injecting medication there and causing a total spinal anesthetic or other nerve damage or paralysis. This procedure must be done without the 'feel' that is possible with the traditional interlaminar epidural injection. Our survey results show that the intensity/complexity measures for Mental Effort and Judgment, Technical Skill and Physical Effort and Psychological Stress are consistently (and often significantly) higher for the code under review than for the reference service.

Patients who undergo transforaminal epidural injections are typically more complex than a patient who undergoes an interlaminar epidural. This results in increased intensity/complexity in all time segments - also illustrated by the survey responses.

Imaging guidance is not bundled into the reference service and that work needs to be considered when valuing the code under review. If we were to base valuation of the service as described by the revised code which bundles the imaging guidance into the value assigned to the injection procedure, we would start by taking the existing value of code 64479 and adding to it the value assigned to fluoroscopic guidance which would result in a work RVU of 2.80. Our participants may not have completely understood that their recommendation for a work RVU was to include both components of the service and that may explain why the survey results for the recommended work RVU don't clearly line up with such a methodology.

Cervical/thoracic injections carries greater risks than lumbar injections. They require more training, and there is an increased risk of liability as complications can be catastrophic. The work RVUs need to acknowledge that distinction and we agree that the relationship between our recommended work RVUs for a cervical transforaminal and a lumbar transforaminal accurately captures that difference.

SERVICES REPORTED WITH MULTIPLE 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.

Code +64480 - Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), cervical or thoracic; each additional level (List separately in addition to code for primary procedure) - is under review at this meeting.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64479

How often do physicians 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? 66586
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 Medicare frequency was 33293. Percentages by specialty are from the RUC database.

Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 24624	Percentage 36.98 %
Specialty Anesthesiology	Frequency 17665	Percentage 26.52 %
pecialty Physical Medicine & Rehabilitation	Frequency 9502	Percentage 14.27 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 33,293 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Per the RUC database, the 2007 Medicare frequency was 33293. Precentages by specialty are from the RUC database.

Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 12312	Percentage 36.98 %
Specialty Anesthesiology	Frequency 8833	Percentage 26.53 %
Specialty Physicial Medicine &Rehabilitation	Frequency 4751	Percentage 14.27 %

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? (ie. similar work RVU, and specialty) No

no, please select another crosswalk and provide a brief rationale. 64479

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:64480 Tracking Number B2 Specialty Society Recommended RVU: **1.20**
Global Period: ZZZ RUC Recommended RVU: **1.20**

CPT Descriptor: Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), cervical or thoracic; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male presents with constant, moderately severe, right arm pain that limits all activity. The patient's history includes a previous laminectomy at C5-6 and C6-7; an MRI with gadolinium, showing small bony spurs at the right C5-6 and C6-7 foramen compressing the C6 nerve root; and neurodiagnostic studies compatible with C6 radiculopathy. He has failed to obtain relief using various oral medications, physical therapy, and traction. He undergoes a transforaminal epidural injection of an anesthetic agent and/or steroid at the C5-6 and C6-7 levels.
[NOTE: Please consider ONLY the work related to the additional injection at the additional level.]

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 55%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 37%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The affected foramen is identified and the skin is infiltrated with local anesthetic. A needle is directed lateral to midline under fluoroscopic guidance into the forarm. Both AP and oblique views are needed to get depth as well as anterior and posterior position. Contrast injection is performed to confirm needle tip location. Once this is completed anesthetic agent and/or steroid is injected. The injection needle is removed and dressing applied.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2009		
Presenter(s):	Marc Leib, MD, JD, Richard Rosenquist, MD, Charles Mick, MD, Rodney Lee Jones, MD, Fred Davis, MD, William Sullivan, MD, Sean Tutton, MD, William Donovan, MD		
Specialty(s):	ASA, NASS, ISIS, AAPM, AAPMR, SIR, ASNR		
CPT Code:	64480		
Sample Size:	1185	**Resp N:** 115	**Response:** 9.7 %
Sample Type:	Panel **Additional Sample Information:** Survey respondents represent a pool of physicians who responded to a website notice soliciting physicians willing to complete these surveys and also physicians who had completed previous surveys.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**10.00**	50.00	850.00
Survey RVW:	0.12	1.20	**1.75**	2.18	6.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	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: 1a-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64480	**Recommended Physician Work RVU: 1.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**13.00**	**-13.00**
Pre-Service Positioning Time:		**0.00**	**1.00**	**-1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**6.00**	**-6.00**
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: 74 **% of respondents:** 64.3 %

TIME ESTIMATES (Median)	**CPT Code: 64480**	**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		

NTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.77	3.69
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.82	3.68
Urgency of medical decision making	3.34	3.18
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.66	4.34
Physical effort required	3.64	3.59
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.72	4.00
Outcome depends on the skill and judgment of physician	4.69	4.32
Estimated risk of malpractice suit with poor outcome	4.68	4.03

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.19	3.09
Intra-Service intensity/complexity	4.30	4.00
Post-Service intensity/complexity	3.05	2.91

Additional Rationale and Comments

escribe 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 Recommendations for the appropriate formula and format.*

This family of codes was flagged for review by the RUC's Five Year Review Identification Workgroup because of fast rate of growth.

Code 64480 is an add-on code associated with base procedure code 64479. When determining a recommended work RVU, we believe that it is more appropriate to analyze the relationship between the add-on code, its base procedure code an other codes within the family rather than to focus on the relationship between this code and code 64627 which serves as th reference service. Code 64627 is also an add-on code but it is linked to a base code with a 010 global while 64479 (the base code for 64480) has a 000 global.

We are recommending that code +64480 be valued at 1.20 work RVUs which is the survey's 25th percentile and lower than its current value of 1.54 work RVUs. Cervical/thoracic injections are more complex than lumbar/sacral injections and the values we are recommending for +64480 and +64484 preserve rank order for these add-on 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. Code 64479 - Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), cervical or thoracic; single level - is under review at this meeting.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64480

How often do physicians 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 Neurosurgery — How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 50518
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Pleas explain the rationale for this estimate. We estimate that the national figure would be twice the Medicare frequency. Per the RUC database, the 2007 Medicare frequency was 25259. Percentages by specialty are from the RUC database.

Specialty Interventional Pain Mgmt/Pain Mgmt — Frequency 21884 — Percentage 43.31 %

Specialty Anesthesiology	Frequency 12003	Percentage 23.75 %
Specialty Neurosurgery	Frequency 6072	Percentage 12.01 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 25,259 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Per the RUC database, the 2007 Medicare frequency was 25259. Percentages by specialty are from the RUC database

Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 10942	Percentage 43.31 %
Specialty Anesthesiology	Frequency 6002	Percentage 23.76 %
Specialty Neurosurgery	Frequency 3036	Percentage 12.01 %

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 64480

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:64483 Tracking Number B3 Specialty Society Recommended RVU: **2.00**
Global Period: 000 RUC Recommended RVU: **1.90**

CPT Descriptor: Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), lumbar or sacral; single level

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71-year-old male presents with recurrent right leg pain, the ability to stand for only 10 minutes and walk less than 1 block, and minimal problems sitting. The patient's history includes a previous laminectomy at L4-5; an MRI with gadolinium, showing a small recurrent herniation between L4-5 with scar tissue; and neurodiagnostic studies compatible with L5 radiculopathy. He has failed to obtain relief using various oral medication, physical therapy, and traction. He undergoes a transforaminal epidural injection of an anesthetic agent and/or steroid at the L5-SI level.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 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? 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: Pre-service work includes review of records and any pertinent imaging studies; communicating with other professionals, patient, and family; and obtaining consent. The pre-service work also includes dressing, scrubbing, and waiting before the procedure, preparing the patient and needed equipment for the procedure, positioning the patient in the prone position on the x-ray table for appropriate fluoroscopic view, and draping of the injection site.

Description of Intra-Service Work: The affected foramen is identified and the skin is infiltrated with local anesthetic. A needle is directed lateral to midline under fluoroscopic guidance into the foramen. Both AP and oblique or lateral views are needed to get depth as well as anterior and posterior position. Contrast injection is performed to confirm needle tip location. Once this is completed anesthetic agent and/or steroid is injected. The injection needle is removed and dressing applied.

Description of Post-Service Work: After the procedure, the patient is taken to the recovery area and observed for any new and unexpected neurological deficits. The physician reviews the procedure and results with the patient and other professionals. The physician evaluates the patient's neurologic condition prior to discharge from the recovery area.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2009		
Presenter(s):	Marc Leib, MD, JD, Richard Rosenquist, MD, Charles Mick, MD, Rodney Lee Jones, MD, Fred Davis, MD, William Sullivan, MD, Sean Tutton, MD, William Donovan, MD		
pecialty(s):	ASA, NASS, ISIS, AAPM, AAPMR, SIR, ASNR		
CPT Code:	64483		
Sample Size:	1185	**Resp N:** 145	**Response:** 12.2 %
Sample Type:	Panel **Additional Sample Information:** Survey respondents represent a pool of physicians who responded to a website notice soliciting physicians willing to complete these surveys and also physicians who had completed previous surveys.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	60.00	**250.00**	500.00	2000.00
Survey RVW:	0.60	1.75	**2.00**	2.40	10.00
Pre-Service Evaluation Time:			**28.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	5.00	10.00	**15.00**	15.00	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 **0.00** 99239x **0.00**
)ffice 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: 1a-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64483	**Recommended Physician Work RVU: 1.90**		
		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:		**5.00**	**1.00**	**4.00**
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**
ischarge 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
62311	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, antispasomodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
57410	000	1.75	**RUC Time**	3,942

CPT Descriptor 2 Pelvic examination under anesthesia (other than local)

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: 68 **% of respondents:** 46.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 64483**	**Key Reference CPT Code: 62311**	**Source of Time RUC Time**
Median Pre-Service Time	24.00	35.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	10.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**49.00**	**70.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.68	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.78	3.49
Urgency of medical decision making	3.15	2.96
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.18	3.59
Physical effort required	3.38	3.15
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.88	3.49
Outcome depends on the skill and judgment of physician	4.24	3.84
Estimated risk of malpractice suit with poor outcome	3.94	3.60

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.24	3.16
Intra-Service intensity/complexity	3.85	3.41
Post-Service intensity/complexity	3.03	2.93

Additional Rationale and Comments

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 family of codes was flagged for review by the RUC's Five Year Review Identification Workgroup because of fast rate of growth. The codes were referred to CPT and the CPT Editorial Panel approved a request to revise the descriptors to

make it clear that imaging guidance (fluoro or CT) was a required element of the service. Per the revised descriptors, that guidance is now to be included in the valuation assigned to the procedures and will no longer be separately reportable.

We recommend pre-service package 1A with modification to the positioning time because the patient is prone and to the scrub/dress/wait time because the procedure is performed under sterile conditions.

The specialties are recommending the survey median of 2.00 work RVUs for code 64483. While the times are indeed lower than those of the reference service, the risk and complexity of a transforaminal epidural injection is higher than that associated with an interlaminar epidural. To perform a transforaminal epidural injection, the physician inserts a needle via the extremely small aperture (size of a small shirt button hole) in the spinal canal through which the nerve root exits on its way to the extremities. The task is to place the needle in that aperture next to that nerve root without injuring either the nerve root or the blood vessels in close proximity, or without entering too far and breaching the dura, thereby inadvertently injecting medication there and causing a total spinal anesthetic or other nerve damage or paralysis. This procedure must be done without the 'feel' that is possible with the traditional interlaminar epidural injection. Our survey results show that the intensity/complexity measures for Mental Effort and Judgment, Technical Skill and Physical Effort and Psychological Stress are consistently (and often significantly) higher for the code under review than for the reference service.

Patients who undergo transforaminal epidural injections are typically more complex than a patient who undergoes an interlaminar epidural. This results in increased intensity/complexity in all time segments - also illustrated by the survey responses.

Imaging guidance is not bundled into the reference service and that work needs to be considered when valuing the code under review. If we were to base valuation of the service as described by the revised code which bundles the imaging guidance into the value assigned to the injection procedure, we would start by taking the existing value of code 64483 and adding to it the value assigned to fluoroscopic guidance which would result in a work RVU of 2.50. Our participants may not have completely understood that their recommendation for a work RVU was to include both components of the service and that may explain why the survey results for the recommended work RVU don't clearly line up with such a methodology.

Cervical/thoracic injections carries greater risks than lumbar injections. They require more training, and there is an increased risk of liability as complications can be catastrophic. The work RVUs need to acknowledge that distinction and we agree that the relationship between our recommended work RVUs for a cervical transforaminal and a lumbar transforaminal accurately capture that difference.

SERVICES REPORTED WITH MULTIPLE 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. Code +64484 - Injection(s), anesthestic agent and/or steroid, transforaminial epidural, with image

guidance (fluoroscopy or CT), lumbar or sacral; each additional level (List separately in addition to code for primary procedure) is under review at this meeting

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'REQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64483

How often do physicians 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? 1157792
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 Medicare frequency was 578896. Percentages by specialty are from the RUC database.

Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 382303	Percentage 33.02 %
Specialty Anesthesiology	Frequency 342128	Percentage 29.55 %
Specialty Physicial Medicine & Rehabilitation	Frequency 273355	Percentage 23.61 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 578,896 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Per the RUC database, the 2007 Medicare frequency was 578896. Percentages by specialty are from the RUC database.

Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 191151	Percentage 33.01 %
Specialty Anesthesiology	Frequency 171064	Percentage 29.55 %
Specialty Physicial Medicine & Rehabilitation	Frequency 136677	Percentage 23.60 %

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 64483

,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:64484 Tracking Number B4 Specialty Society Recommended RVU: **1.00**
Global Period: ZZZ RUC Recommended RVU: **1.00**

CPT Descriptor: Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), lumbar or sacral; lumbar or sacral, each additional level

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71-year-old male presents with recurrent right leg pain, the ability to stand for only 10 minutes and walk less than 1 block, and minimal problems sitting. The patient's history includes previous laminectomy at L3-4 and L4-5; an MRI with gadolinium, showing a small recurrent herniation between L4-5 with scar tissue; and neurodiagnostic studies compatible with L4 and L5 radiculopathy. He has failed to obtain relief using various oral medications, physical therapy, and traction. He undergoes a transforaminal epidural injection of an anesthetic agent and/or steroid at the L4-L5 and L5-S1 levels. [NOTE: Please consider ONLY the work related to the additional injection at the additional level.]

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 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? 26%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The affected additional foramen is identified and the skin is infiltrated with local anesthetic. A needle is directed lateral to midline under fluoroscopic guidance into the foramen. Additional AP and oblique or lateral views are needed to get depth as well as anterior and posterior position. Contrast injection is performed to confirm needle tip location. Once this is completed anesthetic agent and/or steroid is injected. The injection needle is removed and dressing applied.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2009		
Presenter(s):	Marc Leib, MD,JD, Richard Rosenquist, MD, Charles Mick, MD, Rodney Lee Jones, MD, Fred Davis, MD, William Sullivan, MD, Sean Tutton, MD, William Donovan, MD		
Specialty(s):	ASA, NASS, ISIS, AAPM, AAPMR, SIR, ASNR		
CPT Code:	64484		
Sample Size:	1185	**Resp N:** 126	**Response:** 10.6 %
Sample Type:	Panel **Additional Sample Information:** Survey respondents represent a pool of physicians who responded to a website notice soliciting physicians willing to complete these surveys and also physicians who had completed previous surveys.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	25.00	**100.00**	242.50	1500.00
Survey RVW:	0.10	1.00	**1.40**	1.89	6.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	10.00	**10.00**	15.00	45.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 1a-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64484	**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**	**13.00**	**-13.00**
Pre-Service Positioning Time:		**0.00**	**1.00**	**-1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**6.00**	**-6.00**
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
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: 80 **% of respondents:** 63.4 %

TIME ESTIMATES (Median)	**CPT Code: 64484**	**Key Reference CPT Code:** 64623	**Source of Time Harvard Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	10.00	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	**10.00**	**16.00**
Other time if appropriate		

NTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.49	3.45
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.46	3.46
Urgency of medical decision making	3.04	2.94
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.95	3.88
Physical effort required	3.25	3.34
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.75	3.61
Outcome depends on the skill and judgment of physician	4.11	3.98
Estimated risk of malpractice suit with poor outcome	3.85	3.66

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.84	2.85
Intra-Service intensity/complexity	3.46	3.56
Post-Service intensity/complexity	2.65	2.70

Additional Rationale and Comments

escribe 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 Recommendations for the appropriate formula and format.*

This family of codes was flagged for review by the RUC's Five Year Review Identification Workgroup because of fast rate of growth.

Code 64484 is an add-on code associated with base procedure code 64483. When determining a recommended work RVU, we believe that it is more appropriate to analyze the relationship between the add-on code, its base procedure code an other codes within the family rather than to focus on the relationship between this code and code 64623 which serves as th reference service. Code 64623 is also an add-on code but it is linked to a base code with a 010 global while 64483 (the base code for 64484) has a 000 global.

We are recommending that code +64484 be valued at 1.00 work RVUs which is the survey's 25th percentile and lower than its current value of 1.33 work RVUs. Cervical/thoracic injections are more complex than lumbar/sacral injections and the values we are recommending for +64480 and +64484 preserve rank order for these add-on codes

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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)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Code 64483 - Injection(s), anesthetic agent and /or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), lumbar or sacral; single level - is under review at this meeting.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64484

How often do physicians 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? 592208

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 Medicare frequency was 296104. Percentages by specialty are from the RUC database.

Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 226756	Percentage 38.28 %
Specialty Anesthesiology	Frequency 196317	Percentage 33.15 %
Specialty Physical Medicine & Rehabilitation	Frequency 94990	Percentage 16.03 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 296,104 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Per the RUC database, the 2007 Medicare frequency was 296104. Percentages by specialty are from the RUC database.

Specialty Interventional Pain Mgmt/Pain Mgmt	Frequency 113378	Percentage 38.28 %
Specialty Anesthesiology	Frequency 98158	Percentage 33.14 %
Specialty Physicial Medicine & Rehabilitation	Frequency 47495	Percentage 16.03 %

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 64484

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:

64479: Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), cervical or thoracic; single level

64483: Injection(s), anesthetic agent and/or steroid, transforaminal epidural, 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 Society of Neuroradiology (ASNR), and the Society of Interventional Radiology (SIR) was convened to review the practice expense inputs for the newly revised transforaminal epidural 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 new transforaminal epidural 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.

In April 2009 the RUC reviewed 6 new codes for injection of paravertebral facet joints. The staff preparation and support, supplies and equipment for the transforaminal epidural codes are comparable to the facet injection codes. We have recommended a direct crosswalk of the RUC accepted PE times for the preservice, service and post service period for the facet injection codes. The intraservice times for staff have been adjusted to correspond to the physician intraservice times.

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.

Intra-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:

64479: Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

64483: Injection(s), anesthetic agent and/or steroid, transforaminal epidural, 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 Society of Neuroradiology (ASNR), and the Society of Interventional Radiology (SIR) was convened to review the practice expense inputs for the newly revised transforaminal epidural injection codes. The panel included physicians in solo practice, academic settings, and large group practices and represented a multitude of geographic locations.

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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 new transforaminal epidural 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.

In April 2009 the RUC reviewed 6 new codes for injection of paravertebral facet joints. The staff preparation and support, supplies and equipment for the transforaminal epidural codes are comparable to the facet injection codes. We have recommended a direct crosswalk of the RUC accepted PE times for the preservice, service and post service period for the facet injection codes. The intraservice times for staff have been adjusted to correspond to the physician intraservice times.

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.

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
ZZZ Day Global Period
Facility Direct Inputs

CPT Long Descriptor:

64480: Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), cervical or thoracic; each additional level

64484: Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), lumbar or sacral; lumbar or sacral, each additional 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 International Spine Intervention Society (ISIS), the American Academy of Pain Medicine (AAPM), the American Academy of Physical Medicine and Rehabilitation (AAPM&R), the American Society of Anesthesiologists (ASA), the American Society of Neuroradiology (ASNR), and the Society of Interventional Radiology (SIR) was convened to review the practice expense inputs for the newly revised transforaminal epidural injection codes. 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:

N/A

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
ZZZ Day Global Period
Non Facility Direct Inputs

CPT Long Descriptor:

64480: Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), cervical or thoracic; each additional level

64484: Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), lumbar or sacral; lumbar or sacral, each additional 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 Society of Neuroradiology (ASNR), and the Society of Interventional Radiology (SIR) was convened to review the practice expense inputs for the newly revised transforaminal epidural injection codes. 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:

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:

N/A

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1				64479			64480			64483			64484		
2	AMA Specialty Society RVS Update Committee Recommendation Meeting Date: September 2009			Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), cervical or thoracic; single level			Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), cervical or thoracic; each additional level			Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), lumbar or sacral; single level			Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), lumbar or sacral; lumbar or sacral, each additional level		
3				Non Facility		Facility	Non Facility		Facility	Non Facility		Facility	Non Facility		Facility
4	GLOBAL PERIOD			000	000	000	ZZZ	ZZZ	ZZZ	000	000	000	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
6	TOTAL CLINICAL LABOR TIME			22.0	59.0	24.0	15.0	15.0	0.0	22.0	59.0	24.0	10.0	10.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			3.0	11.0	21.0	0.0	0.0	0.0	3.0	11.0	21.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			19.0	45.0	0.0	15.0	15.0	0.0	19.0	45.0	0.0	10.0	10.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	3.0	3.0	0.0	0.0	0.0	0.0	3.0	3.0	0.0	0.0	0.0
10	PRE-SERVICE														
11	Start: Following visit when decision for surgery or procedure made														
12	Complete pre-service diagnostic & referral forms				3	3					3	3			
13	Coordinate pre-surgery services					5						5			
14	Schedule space and equipment in facility					5						5			
15	Provide pre-service education/obtain consent				5	5					5	5			
16	Follow-up phone calls & prescriptions				3	3					3	3			
17	Other Clinical Activity (please specify)- Pull & hang prior imaging studies for MD to review			3						3					
18	End: When patient enters office/facility for surgery/procedure														
19	SERVICE PERIOD														
20	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure														
21	Review charts														
22	Greet patient and provide gowning, assure appropriate medical records are available and perform surgical checklist				5						5				
23	Obtain vital signs				5						5				
24	Prepare room, equipment, supplies				2						2				
25	Prepare and position patient/ monitor patient/ set up IV			2	2					2	2				
26	Intra-service														
27	Assist physician in performing procedure			15	15		15	15		15	15		10	10	
28	Post-Service														
29	Monitor pt following service/check tubes, monitors, drains				10						10				
30	Clean room/equipment by physician staff				3						3				
31	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				3						3				
32	Other Clinical Activity (please specify) Process, hang, file films and review study with interpreting MD			2						2					
33	End: Patient leaves office														
34	POST-SERVICE Period														
35	Start: Patient leaves office/facility														
36	Conduct phone calls/call in prescriptions				3	3					3	3			
37	End: with last office visit before end of global period														

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1				64479			64480			64483			64484		
2	**AMA Specialty Society RVS Update Committee Recommendation Meeting Date: September 2009**			**Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), cervical or thoracic; single level**			**Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), cervical or thoracic; each additional level**			**Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), lumbar or sacral; single level**			**Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), lumbar or sacral; lumbar or sacral, each additional level**		
3				**Non Facility**		**Facility**	**Non Facility**		**Facility**	**Non Facility**		**Facility**	**Non Facility**		**Facility**
38	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**												
39	pack, basic injection	SA041	item		1						1				
40	pack, minimum multi specialty visit	SA048	item		1						1				
41	drape, sterile, c-arm, fluoro	SB008	item		1						1				
42	Spinal Needle	SC028	item		1			1			1			1	
43	Syringe 10cc	SC051	item		1						1				
44	Syringe 3cc	SC055	item		1						1				
45	film, dry, radiographic, 8in x 10in	SK025	item		2						2				
46	film, fluoroscopic, 14 x 17	SK028	item												
47	x-ray developer solution	SK089	item												
48	x-ray fixer solution	SK092	item												
49	**Equipment**														
50	stretcher	EF018	min		40						40				
51	room, radiographic-fluoroscopic	EL014	min		27			15			27			10	
52	x-ray view box, 4 panel	ER067	min		27			15			27			10	
53	printer, dye sublimation (photo, B&W)	ED031	min		27			15			27			10	
54	film processor, wet	ED025	min												
55	film alternator	ER029	min												
56	pulse oximeter	EQ211	min		24										

September 8, 2009

Bill Moran, MD
Chair, Practice Expense Subcommittee
RVS Update Committee
American Medical Association
515 N. State St.
Chicago, IL 60654

Dear Dr. Moran:

During the April 2009 RUC meeting, six new codes for the injection of spinal facet joints were presented. The PERC and RUC discussed the imaging equipment typically required when these procedures are performed in an office setting. In the RUC database in the past, office based interventional pain procedures were assigned to a fluoroscopy procedure room. These procedures currently are typically performed in a dedicated procedure room furnished with a mobile C-arm image intensifier. To our knowledge, CMS has not created a separate equipment category that captures these costs.

Our consensus panel has estimated the following typical costs to construct and supply a modern office interventional pain procedure room. The largest cost is the mobile C-arm. These devices vary in cost and quality. Current practice requires a machine capable of high resolution images in patients of a variety of body sizes and shapes. While lower quality machines can produce images, they are not of sufficient resolution to safely position needles for spinal procedures. The field is currently evaluating the role of digital subtraction image processing to further enhance image quality and improve safety but this is not yet the standard. Modern radiographic imaging has transitioned to digital for image display and capture. Image storage is a mix of print and electronic with the typical office system using a laser printer to produce hard copies.

Mobile C-arm	$110,000-125,000
Service contract (per year)	$25,000
Adjustable fluoroscopy table	$25,000
Laser printer (ED031)	$2,322
Digital display system (ED021)	$2,500
State required room modifications (eg MA)	$30,000
Lead lined or double thickness drywall	
Extra wide, solid core, self closing doors	
Separate HVAC ventilation system	
Outside wall location/concrete floor	
Estimated Total	**$194,822 - $209,822**

We have requested actual invoices and price quotes from various regions of the country from interventional pain physicians and will have this information ready for presentation to the PERC/RUC in October.

Sincerely,

American Academy of Pain Medicine
American Academy of Physical Medicine and Rehabilitation
American Society of Anesthesiologists
American Society of Neuroradiology
International Spine Intervention Society
North American Spine Society
Society of Interventional Radiology

AMA/Specialty Society RVS Update RUC
Summary of Recommendations
Originated from the Five-Year Review – High IWPUT Screen

April 2010

Iridotomy/Iridectomy

In February 2008, CPT code 66761 *Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)* was identified by the RUC's Five-Year Identification Workgroup through the CMS High IWPUT Screen. The Workgroup determined that although the RUC had reviewed this service at the 2005 Five-Year Review, it required further analysis, specifically addressing a change in number of sessions.. At the April 2009 RUC meeting, the Workgroup agreed with the specialty that the service was difficult to survey for physician work with a 090-day global period and the descriptor of one or more sessions. The RUC requested consideration of valuing this procedure as a single surgical session with a 010-day global period. In February 2010, the CPT Editorial Panel revised code 66761 to state "per session" instead of "1 or more sessions" to address the Five-Year Review Identification Workgroup's determination and CMS's consent that this procedure be valued as a single surgical session with a 010-day global.

1179

66761
The RUC reviewed the survey results from 62 ophthalmologists for physician work, time, and intensity recognizing the descriptor and the global period changes and the current work value of 5.02. The 25th percentile survey results were recommended by the specialty (3.99), however the RUC disagreed with the survey respondents choice of reference code 65855 *Trabeculoplasty by laser surgery, 1 or more sessions (defined treatment series)* (Work RVU = 3.99) as its intra-service time was one third higher than 88761 and includes an additional office visit. 65855 is also used to report one or more sessions, while 66761 is reported per session. The RUC agreed a better reference service was 12052 *Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (Work RVU = 2.87, 28 minutes intra-service time, 010 global. The RUC compared this reference code to 66761 and noted that the surveyed code is a more intense service to perform, despite the similar total service time. a). Based on this comparison, the specialty society recommends and the RUC agrees that the low of the specialty's survey results of 3.00 RVUs (IWPUT = 0.1169) most accurately represents the work associated with this service. **The RUC recommends a relative work value of 3.00 for 66761.**

Work Neutrality
The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense: The RUC recommends the reduced direct practice expense inputs that reflect the typical patient scenario with the change in the CPT descriptor and global period for code 66761.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲66761	FF1	Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)	~~090~~ 010	3.00

1180

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:66761 Tracking Number FF1 Specialty Society Recommended RVU: **3.99**

Global Period: 010 RUC Recommended RVU: **3.00**

CPT Descriptor: Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67 year old female with narrow angles who is at risk for acute angle closure glaucoma.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 10% , In the ASC 21%, In the office 69%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

moderate sedation inherent 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: A history including reference to recent use of anticoagulants. If a bleeding tendency is detected or the patient is on a high-risk anticoagulant, the method of laser therapy is modified by using both an argon and YAG laser. Prior to laser surgery, topical pilocarpine is instilled in order to achieve miosis that will occur after about 15 minutes. A topical alpha agonist is instilled to blunt an IOP rise and to decrease bleeding. Following topical instillation of an anesthetic drop, the patient is positioned at the laser. The function of the laser is tested.

Description of Intra-Service Work: The patient's ability to tolerate and cooperate with treatment along with, chamber depth, corneal clarity, iris thickness, and inflammation are considered for the procedure. A coupling gel is placed on the iridotomy contact lens. The lens is placed on the eye in order to stabilize the globe and allow magnification of the iris. After the laser settings are set, an opening is made in the iris. The location of the iridotomy varies according to surgeon preference. After completion of the iridotomy, it is inspected for hemorrhage. If there is bleeding from the iridotomy, pressure is applied to the eye until vascular closure occurs. The contact lens is removed. The eye is irrigated profusely to remove the coupling gel. A second drop of alpha agonist is instilled to decrease the IOP spike. A topical corticosteroid is applied.

Description of Post-Service Work: Additional topical steroid drop is instilled in 15-30 minutes. The IOP is rechecked 30-60 minutes after laser therapy to look for an acute rise. The physician checks for the patency of the iridotomy. If IOP is markedly elevated, additional anti-glaucoma medications are instilled and the IOP rechecked. When the IOP is acceptable,

the patient is given instructions to instill postoperative corticosteroid drops over the next week. The patient returns for repeat IOP and further evaluation at one week. Dilating drops are instilled if the angle is found to be open adequately. A dilated fundus exam is performed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Stephen A. Kamenetzky, M.D. and Cindie Mattox, M.D.				
Specialty(s):	Ophthalmology				
CPT Code:	66761				
Sample Size:	250	**Resp N:** 62	**Response:** 24.8 %		
Sample Type:	Random **Additional Sample Information:** Random sample of members who indicated interest in glaucoma and random sample from American Glaucoma Society membership database				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	21.25	**37.50**	60.00	500.00
Survey RVW:	3.00	3.99	**4.10**	4.81	10.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**3.00**		
Intra-Service Time:	2.00	8.00	**10.00**	15.00	25.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **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: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	66761	**Recommended Physician Work RVU: 3.99**		
		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:		**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):	**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
65855	010	3.99	**RUC Time**

CPT Descriptor Trabeculoplasty by laser surgery, 1 or more sessions (defined treatment series)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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
11624	010	3.62	**RUC Time**	9,339

CPT Descriptor 1 Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11644	010	4.34	**RUC Time**	16,242

CPT Descriptor 2 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm

Other Reference CPT Code	Global	Work RVU	Time Source
66821	090	3.42	**RUC Time**

CPT Descriptor Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (1 or more stages)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time 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:** 82.2 %

TIME ESTIMATES (Median)	**CPT Code: 66761**	**Key Reference CPT Code: 65855**	**Source of Time RUC Time**
Median Pre-Service Time	7.00	15.00	
Median Intra-Service Time	10.00	15.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	39.0	32.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	**66.00**	**72.00**
Other time if appropriate		

NTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.67	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.35	3.53
Urgency of medical decision making	3.51	3.06
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.76	3.75
Physical effort required	2.98	2.96
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.20	2.76
)utcome depends on the skill and judgment of physician	3.65	3.47
Estimated risk of malpractice suit with poor outcome	3.33	2.75

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.20	2.94
Intra-Service intensity/complexity	3.35	3.35
Post-Service intensity/complexity	2.82	2.65

Additional Rationale and Comments

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.*

CPT 66761 was identified by the Five Year Review Work group because of a high IWPUT picked up on the screening analysis. The specialty society explained that this high IWPUT was due to the fact that the descriptor *"Iridotomy/iridectomy by laser surgery (e.g., for glaucoma) (1 or more sessions)"* included the difficult to survey "1 or more sessions" and had a 90-day global period. The typical patient required more than one session which was why the global period was 90 days. AAO also pointed out that the time value was for one session, while the work value was for more than one session which made the IWPUT artificially high. The value of the code was confirmed during the Five Year Review conducted in 2005, the current value is 5.02.

AAO indicated to the current Five Year Review Work group that the laser technology has evolved to the point where, with a different laser system, the typical patient requires only one treatment session. The society further suggested that the global period should change from 90 days to 10 days as the recovery period related to the laser treatment itself was much shorter and visits subsequent to 10 days were to deal with the underlying disease process rather than post-laser issues. The Work Group and CMS agreed. The code was taken to CPT for a descriptor change. This new code was the object of the survey being presented.

When this code was surveyed for the 5 Year Review in 2005, the 25th percentile was 3.88 RVU and the median 4.00 RVU. The 75th percentile was 4.88. For the current survey, there were 62 survey respondents (nearly 25% response rate) and 97% felt that the vignette was typical. **The 25th percentile for WRVU was 3.99 and the median 4.10**. The 75th percentile was 4.81 WRVU and the lowest value XXX. Median times were 15 minutes pre-service for evaluation and positioning; 3 min scrub, dress, wait; 10 min intra-service time; and 10 minutes post-service time. The primary reference code chosen was 65855 *Trabeculoplasty by laser surgery, one or more sessions (defined treatment series)* a 10 day global code with a WRVU of 3.99. This reference service was RUC reviewed in 2000. The survey respondents felt that the iridotomy code was higher in intensity for decision-making and psychological stress and required about the same amount of technical skill. There were 2 post-operative visits during the 10-day period, the first (99212) on day 1 and then a second at one week (99213) where the pupil was dilated if the iridotomy remained patent.

An expert consensus panel familiar with the RUC process and the surgical procedure reviewed the survey results. The typical site of service is the office setting and non-facility package 5 was chosen and therefore we reduced the pre-service time for that setting to 7 minutes from 18. It was felt that the intra-service and post-service times from the survey were accurate and therefore the final times submitted are **7/10/10 minutes**.

The panel reviewed the work values for both the reference and the surveyed codes. The intra-service time for the reference code was longer than for iridotomy (66761). However, as noted the intensity and psychological stress were greater because of the risk of a failed iridotomy procedure allowing an angle closure attack. In addition a difficult laser procedure is associated with more intraocular inflammation. There was also some confusion regarding the number of post-operative visits for the reference code, 65855. The RUC database lists three 99212 visits but the RUC rationale in the same entry indicates that one of these visits was subtracted from the value of 65855 (0.45RVU) and the number reduced to two. We are assuming the correct answer is two visits Thus the two codes have the same number of visits in the 10-day global, but one of the visits for the iridotomy code is at the 99213 level to allow a dilated examination.

The panel felt that the 25th percentile of the survey accurately reflected the total work of the procedure. The value was the same as that for the reference code. Although the surgical time is shorter for iridotomy, the post-operative work for the iridotomy was greater because there is a level 3 (99213) dilated examination performed which is not done with the reference procedure. This difference adds 0.49 WRVU to the total work of the procedure when compared to the reference code. **The society recommends a WRVU of 3.99, the 25th percentile of the survey.**

The value recommended is less than that for a surgical iridectomy (CPT 66630), a Harvard-valued code which has an RVU of 7.28. This reflects the lower complexity of the laser procedure. YAG laser capsulotomy 66821 has the same pre- and intra-service times and two 99213 post operative visits in a 90-day global period. It is valued at 3.42 RVU. The YAG capsulotomy (66821) procedure is much less risky than 66761 because there is no risk of an acute attack of glaucoma as a result of the treatment. CPT 27250 (closed reduction of a hip dislocation) was RUC reviewed in Feb 2008 is a 000 global with a WRVU of 3.82.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) same

How often do 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 Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 100000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Ophthalmology Frequency 100000 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? 85,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty Ophthalmology Frequency 85000 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? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. simil work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 68816

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

	A	B	C	D	E
1	AMA/Specialty Society RVS Update Committee Recommendation				
2				66761	
3	**Meeting Date: April 2010**	CMS		Iridotomy/iridectomy by laser surgery (eg, for glaucoma)(1 or more sessions, per session)	
4	**LOCATION**	**Code**	**Staff Type**	**Non Facility**	**Facility**
5	**GLOBAL PERIOD**			**10**	**10**
6	**TOTAL CLINICAL LABOR TIME**			**105.0**	**76.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**8.0**	**13.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**34.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**63.0**	**63.0**
10	**PRE-SERVICE**				
11	**Start: Following visit when decision for surgery or procedure made**				
12	Complete pre-service diagnostic & referral forms	L038A	COMT/COT/RN/CST	**5**	**5**
13	Coordinate pre-surgery services	L038A	COMT/COT/RN/CST		
14	Schedule space and equipment in facility	L038A	COMT/COT/RN/CST		**5**
15	Provide pre-service education/obtain consent	L038A	COMT/COT/RN/CST		
16	Follow-up phone calls & prescriptions	L038A	COMT/COT/RN/CST	**3**	**3**
17	Other Clinical Activity (please specify)				
18	**End:When patient enters office/facility for surgery/procedure**				
19	**SERVICE PERIOD**				
20	**Start: When patient enters office/facility for surgery/procedure**				
21	**Pre-service services**				
22	Review charts				
23	Greet Patient and Provide Gowning, Ensure Appropriate Medical Records Are Available	L038A	COMT/COT/RN/CST	**3**	
24	Obtain vital signs	L038A	COMT/COT/RN/CST	**3**	
25	Provide pre-service education/obtain consent	L038A	COMT/COT/RN/CST	**5**	
26	Prepare room, equipment, supplies	L038A	COMT/COT/RN/CST	**2**	
27	Setup scope (non facility setting only)				
28	Prepare and position patient/ monitor patient/ set up IV	L038A	COMT/COT/RN/CST	**2**	
29	Sedate/apply anesthesia				
30	**Intra-service**				
31	Assist physician in performing procedure	L038A	COMT/COT/RN/CST	**10**	
32	**Post-Service**				
33	Monitor pt following service/check tubes, monitors, drains	L038A	COMT/COT/RN/CST	**3**	
34	Clean room/equipment by physician staff	L038A	COMT/COT/RN/CST	**3**	
35	Clean Surgical Instrument Package				
36	Complete diagnostic forms, lab & X-ray requisitions				
37	Review/read X-ray, lab, and pathology reports	L038A	COMT/COT/RN/CST		
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L038A	COMT/COT/RN/CST	**3**	
39	Discharge day management 99238 --12 minutes				
40	Other Clinical Activity (please specify)				
41	**End: Patient leaves office**				
42	**POST-SERVICE Period**				
43	**Start: Patient leaves office/facility**				
44	Conduct phone calls/call in prescriptions				
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	**1**	**1**
49	99214 53 minutes		53		
50	99215 63 minutes		63		
51	Other				
52	*Total Office Visit Time*			**63**	**63**
53	Other Activity (please specify)				
54	**End: with last office visit before end of global period**				
55	**MEDICAL SUPPLIES**		**Unit**		
56	Ophthalmology visit pack	SA082	item	**3**	**2**
57	Iopidine 1% 0 1ml	SH044	item	**1**	
58	Pilocarpine 2%		ml	**1**	
59	Goniosol	SH037	ml	**1**	
60	predisolone acetate 1%	SH057	ml	**1**	
61					
62	**Equipment**				
63	Exam Lane	EL005	item	**97.0**	**63**
64	Laser, YAG	EQ157	Item	**34.0**	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five-Year Review – CMS Fastest Growing Screen and Site of Service Anomaly Screen

April 2010

Labrinthotomy

CPT codes 69801 *Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal* and 69802 *Labyrinthotomy, with perfusion of vestibuloactive drug(s); with mastoidectomy* were identified for review through both the CMS Fastest Growing and Site of Service Anomaly Screens. The specialty acknowledged that 69801 is performed entirely in the outpatient setting. After its initial identification in September 2007, the specialty society attempted to survey 69801 and 69802 in October 2009 but found that the survey respondents were confused by the ambiguity of the CPT descriptors and found it difficult to value the services as a single or series of perfusions. The services were referred to the CPT Editorial Panel, and in February 2010 the CPT codes were revised to indicate a single perfusion. Therefore, the specialty suggested that a change from a 090 day global to a 000 day global was necessary to accurately capture the physician work. CMS agreed with a change in the global period from 090 to 000.

1193

69801
The RUC reviewed the survey results from 30 otolaryngologists for code 69801 and agreed with the specialty that the survey respondents accurately captured the physician intra-service and post service time necessary to complete this procedure, but overestimated the pre-service time. The RUC agreed that pre-service time package 6 (Non-facility procedure with sedation/anesthesia care) was accurate for this procedure because local anesthesia is necessary and the procedure would typically be performed in an office. The pre-service time package was then reduced by 5 minutes in the evaluation time, for a total of 18 pre-service minutes, to more accurately reflect the typical interpretation and discussion of previous evaluations that the physician is having with the patient. In addition, the RUC agreed that the survey median intra-service time of 15 minutes and post service time of 10 minutes accurately accounted for the physician time involved in performing the service.

The RUC compared code 69801 to the Key Reference Service 31579 *Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy* (Work RVU= 2.26 and intra-service time= 15 minutes). The RUC agreed that the services are analogous in both physician work and total time, with 43 minutes for 69801 and 45 minutes for 31579. The RUC also agreed that the surveyed service should be slightly lower than the reference service to account for the slight difference in intensity. Finally, the RUC compared the surveyed code to MPC code 52000 *Cystourethroscopy* (Work RVU= 2.23, intra-service time= 15 minutes) and determined that the reference code, while

having similar total time, 43 minutes and 42 minutes, respectively, should be valued relatively higher than CPT code 69801 to account for increased intensity and complexity. Given this information, the RUC agreed with the survey's 25th percentile of 2.06 work RVUs, ensuring appropriate relativity. **The RUC recommends 2.06 work RVUs for 69801.**

69802
Prior to surveying this service for RUC valuation, the specialty society determined that this service is outdated and infrequently performed, with only 13 claims submitted in 2008. Therefore, the RUC agreed that the specialty should request this code be deleted by the CPT Editorial Panel. **The RUC recommends 69802 be referred to the CPT Editorial Panel for deletion.**

Practice Expense
The RUC reviewed the direct practice expense for 69801 and 69802 and recommends minor modifications to the clinical labor inputs.

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.

1194

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲69801	HH1	Labyrinthotomy, with ~~or without cryosurgery including other nonexcisional destructive procedures or~~ perfusion of vestibuloactive drug(s) ~~(single or multiple perfusions)~~; transcanal ~~(69801 includes all required infusions performed on initial and subsequent days of treatment)~~ (Do not report code 69801 more than once per day) (Do not report 69801 in conjunction with 69420, 69421, 69433, 69436 when performed on the same ear)	~~090~~ 000	2.06
▲69802	HH2	with mastoidectomy	090	Refer to CPT for deletion

1195

AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY

March 26, 2010

Barbara Levy, MD, FACS
Chair, AMA/RUC
American Medical Association
515 N. State Street
Chicago, IL 60654

Dear Dr. Levy-

In February, the CPT Editorial Panel accepted with modification a request to:

1) revise codes 69801 and 69802;
2) remove the reference to multiple perfusions;
3) delete the instructional parenthetical note following code 69801;
4) add an exclusionary parenthetical note to 69801.

Additionally, CMS agreed with the recommendation to change the global period for code 69801 from 090 to 000. The CPT Editorial Panel discussions associated with changes in 69802 indicated they would be editorial in nature.

The RUC has requested review of both codes 69801 and 69802. Upon further discussion with otolaryngology subspecialty representatives that are familiar with these procedures, we have determined that code 69802 is an outdated combination procedure that is infrequently performed.

It was clear from our discussions with otology specialists that we would be unable to get an adequate number of physicians sufficiently familiar with the procedure to conduct a valid RUC survey. Therefore, we will be requesting deletion of 69802 from the CPT Editorial Panel.

We are conducting a RUC survey of 69801 and will present a recommendation to the RUC at the April meeting. If you have any questions about this issue, please contact Ms. Tricia Bardon at (703) 535-3725 or tbardon@entnet.org.

Sincerely,

Wayne Koch, MD, FACS
AAO-HNS RUC Advisor

Cc: Sherry Smith
Marie Mindeman

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:69801 Tracking Number HH1 Specialty Society Recommended RVU: **2.06**

Global Period: 000 RUC Recommended RVU: **2.06**

CPT Descriptor: Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old white female presents with weekly episodic vertigo spells lasting hours. During the spell she has associated ear fullness, hearing loss, and tinnitus of the right ear. Maximal medical management has failed and she has opted for destruction of the inner ear with a vestibuloactive agent.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Previous records are reviewed to ensure correct ear is being treated with the appropriate medication. This includes history, physical exam, scans, audiograms, ENGs, and outside records. The medication is prepared, ensuring correct volume and concentration. Availability of instruments is confirmed. The physician explains the procedure and obtains consent. In the procedure room, the microscope is positioned, checked and adjusted. Local anesthetic is administered.

Description of Intra-Service Work: Under microscopic visualization, the ear canal is cleaned and the tympanic membrane is visualized. The medication is delivered through a small incision or needle puncture of the tympanic membrane. A second incision or puncture is made, as necessary. The patient is re-positioned with the affected ear up and monitored closely by a nurse. The ear is suctioned clean under the microscope and examined for any bleeding.

Description of Post-Service Work: Post-procedure care of the ear and activity restrictions are discussed with the patient/family. Medication orders are written. A procedure note is dictated for the medical record and sent to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Peter Weber, MD; Wayne Koch, MD				
Specialty(s):	otolaryngology				
CPT Code:	69801				
Sample Size:	89	**Resp N:**	30	**Response:** 33.7 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**15.00**	40.00	250.00
Survey RVW:	1.20	2.06	**3.00**	4.52	6.00
Pre-Service Evaluation Time:			**32.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	4.00	6.00	**15.00**	20.00	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: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	69801	**Recommended Physician Work RVU: 2.06**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**12.00**	**17.00**	**-5.00**
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:		**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
31579	000	2.26	**RUC Time**

CPT Descriptor Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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**	926,353

CPT Descriptor 1 Cystourethroscopy (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
54150	000	1.90	**RUC Time**	136

CPT Descriptor 2 Circumcision, using clamp or other device with regional dorsal penile or ring block

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

PT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 16.6 **%**

TIME ESTIMATES (Median)	CPT Code: 69801	Key Reference CPT Code: 31579	Source of Time RUC Time
Median Pre-Service Time	18.00	15.00	
Median Intra-Service Time	15.00	15.00	
Median Immediate Post-service Time	10.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**43.00**	**45.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	3.60
Urgency of medical decision making	4.00	3.40
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.20	3.20
Physical effort required	3.60	3.20
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.80	3.20
Outcome depends on the skill and judgment of physician	4.40	3.60
Estimated risk of malpractice suit with poor outcome	4.20	3.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.80	3.00
Intra-Service intensity/complexity	4.40	3.00
Post-Service intensity/complexity	3.20	2.40

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT code 69801 was identified for review through the *fastest growing* screen and *site of service anomaly* screen. A RUC survey in 2009 produced data that indicated the survey respondents were confused by the ambiguity of the CPT descriptor, specifically whether the data was based on a single or series of perfusions. The RUC recommended referral of the issue to CPT.

A CPT proposal was submitted to revise the language for 69801 to more accurately reflect current practice. The installation of vestibulotoxic medications to the labyrinth is well documented as an effective means for the treatment of Meniere's disease. Also well documented is the similar use of corticosteroids to the inner ear for sensorineural hearing loss. However, the frequency, number of injections, and the agent has changed over time and varies considerably based on protocol and clinical presentation. To capture the true work involved for this procedure, the AAOHNS suggested that the code descriptor be revised and that the global period should be 0-days. CPT approved the revision to the descriptor and CMS assigned a 0-day global period.

The AAOHNS conducted a RUC survey and received 30 responses. The consensus panel notes that when Harvard reviewed this service over 20 years ago, only intra-time was collected, based on the response of 11 otolaryngologists. Medicare utilization in 1993 for 69801 was 98. National frequency was probably not significantly greater. With such a low frequency, we believe the Harvard study estimates for intra-time may have been made by surgeons who were not familiar with the procedure as currently performed.

The consensus panel reviewing the survey data for this procedure agree that the median intra-time of 15 minutes accurately reflects the time for the procedure as currently performed and described above. The survey data compares well with the time details for the key reference code 31579 *Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy* (RVW=2.26). The consensus committee does not believe the work of 69801 is greater than 31579, and therefore, we are recommending the survey 25th percentile RVW of 2.06.

To support the recommendation of 2.06, the consensus panel looked at two MPC codes that have the same intra-time, similar total time, and work RVUs just above and below the recommendation: 52000 *Cystourethroscopy (separate procedure)* (RVW=2.23) and 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (RVW=1.90). The consensus panel also reviewed MPC code 31575 *Laryngoscopy, flexible fiberoptic; diagnostic*. Using magnitude estimation, we believe the physician work for 69801 is *about twice* the work of 31575 [69801: RVW=2.06; intra=15 min; total=48 min *versus* 31575: RVW=1.10; intra=8 min; total=28 min].

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69801

How often do physicians 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 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. not able to estimate national frequency

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,702
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2008 Medicare data

Specialty otolaryngology Frequency 4643 Percentage 98.74 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society RVS Update Committee Recommendation

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
000, 010, or 090 Day Global Periods
Direct Inputs

CPT Long Descriptor:

GLOBAL	CPT	DESCRIPTOR
000	69801	Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
A joint specialty panel representing general otolaryngologists and neurotologists reviewed the practice expense details developed in 2004 for 69801 as a facility only 90-day global procedure. Code 69801 global period has be assigned a new global period of 0-days and requires practice expense inputs for performing the procedure in an office setting.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
Non-facility: The global period will not impact the typical 5 minutes for diagnostic and referral forms necessary to perform this service, compared with a 90-day global procedure. Pre-surgery clearance will require at least one phone call (3 min). The patient will be contacted prior to surgery to verify prescribed changes in medications and pre-operative cleansing and diet (3 min).
Facility: The global period will not impact the typical 5 minutes for diagnostic and referral forms necessary to perform this service, compared with a 90-day global procedure. Pre-surgery clearance with PCP and anesthesia services will require at least two phone calls (6 min). Scheduling facility space and equipment/supplies will require at least one phone call (3 min). Pre-service education and review of peri-operative expectations, possible complications, and consent (5 min). The patient will be contacted prior to surgery to verify prescribed changes in medications and pre-operative cleansing and diet (3 min).

Intra-Service Clinical Labor Activities:
Non-facility: Clinical staff will assemble/review prior imaging, lab, and/or pathology reports as necessary to be certain all pertinent materials are available for the physician. The procedure room is prepared for a procedure that includes irrigation. The patient is escorted to the procedure room and a gown is provided. Vitals are taken. The procedure and possible complications are reviewed. Assist physician with patient positioning and positioning of equipment. Assist the physician in performing the procedure (100% of physician time). Monitor after the procedure for untoward reactions (15 minutes to periodically check on patient during a typical 30-60 minutes period). Review at home activities and medication restrictions needs. Clean room and equipment, including instruments.

Facility: Clinical staff communicates with the facility staff, patient's family, insurance staff, and PCP/referring physician regarding discharge instructions and follow-up requirements. The standard 6-minutes for outpatient has been applied, as appropriate.

Post-Service Clinical Labor Activities: **N/A**

	A	B	C	D	E	F	G
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**Jan 2004**		**Apr 2010**	
2	**Meeting Date: April 2010**			**69801**		**69801**	
3				Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of		Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal	
4	**LOCATION**	**Code**	**Staff Type**	**OFF**	**FAC**	**OFF**	**FAC**
5	**GLOBAL PERIOD**			**090**	**090**	**000**	**000**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**198**	**75**	**25**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**75**	**11**	**22**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**12**	**64**	**0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**n/a**	**111**	**0**	**3**
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**
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA		**20**	**3**	**6**
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA		**8**		**5**
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA		**20**		**3**
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA		**7**	**3**	**3**
17	Other Coordination of care - multidiscipline	**L037D**	RN/LPN/MTA		**15**	**0**	**0**
18	**End:When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters site for procedure: Services Prior to Procedure**						
21	Greet patient, provide gowning, ensure appropriate medical records are available	**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			**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	**L037D**	RN/LPN/MTA				
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			**15**	
32	Clean room/equipment by physician staff	**L037D**	RN/LPN/MTA			**3**	
33	Clean Scope	**L037D**	RN/LPN/MTA			**0**	
34	Clean Surgical Instrument Package	**L037D**	RN/LPN/MTA			**15**	
35	Complete diagnostic forms, lab & X-ray requisitions	**L037D**	RN/LPN/MTA			**0**	
36	Review/read X-ray, lab, and pathology reports	**L037D**	RN/LPN/MTA			**0**	
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	**L037D**	RN/LPN/MTA			**3**	
38	Discharge day management	**L037D**	RN/LPN/MTA		**12**	**0**	
39	Other Clinical Activity follow-up phone call	**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					**0**	**3**
44	*Office visits:*						
45	*List Number and Level of Office Visits*						
46	99211 16 minutes		16				
47	99212 27 minutes		27		**3**		
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**	**0**	**81**	**0**	**0**
53	*Other Clean* Instruments @ 2/3 Std Time	**L037D**	**RN/LPN/MTA**		**30**		
54	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**Jan 2004**		**Apr 2010**	
2	**Meeting Date: April 2010**			**69801**		**69801**	
3				Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of		Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal	
4	**LOCATION**	**Code**	**Staff Type**	**OFF**	**FAC**	**OFF**	**FAC**
55	**MEDICAL SUPPLIES**	**Code**	**Unit**				
56	**GOWN / DRAPE**						
57	pack, minimum multi-specialty visit	SA048	pack			1	
58	gown, staff, impervious	SB027	item		6	2	
59	mask, surgical	SB033	item			2	
60	gloves, sterile	SB024	pair		1	2	
61	drape, sterile, for Mayo stand	SB012	item		3	1	
62	underpad 2ftx3ft (Chux)	SB044	item		3		
63	mask, surgical, with face shield	SB034	item		6		
64	gown, patient	SB026	item		3		
65	pack, post-op incision care (suture & staple)	SA053	pack		1		
66	**PROCEDURE**						
67	basin, emesis	SJ010	item		3	1	
68	cotton ball, sterile	SG082	item		3	1	
69	phenol, liquified, USP	SH088	ml			1	
70	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml			1	
71	swab-pad, alcohol	SJ053	item			2	
72	syringe 1ml	SC052	item			2	
73	needle, 18-27g	sc029	item			4	
74	atomizer tip shield (RhinoGuard)	SM001	item		3		
75	Cipro HC otic soln	SH024	ml		3		
76	applicator, cotton-tipped, sterile, 6in	SG008	item		12		
77	cottonoid	SG031	item		3		
78	tincture of benzoin, swab	SJ060	item		1		
79	bacitracin oint (0.9gm uou)	SJ007	item		15		
80	gauze, sterile 4in x 4in	SG055	item		10		
81	hydrogen peroxide	SJ028	ml		30		
82	silver nitrate applicator	SJ046	item		15		
83	adhesive remover, pad (acetone)	SG006	item		1		
84	**SUCTION**						
85	canister, suction	SD009	item		3	1	
86	tubing, suction, non-latex (6ft uou)	SD132	item		6	1	
87	tubing, suction, non-latex (2ft) with Frazier tip (1)	SD214	item			1	
88	water, sterile for irrigation (250-1000ml uou)	SH074	item			1	
89	cup-container, sterile, graduated 1000ml	SL038	item			1	
90	**DRESSING**						
91	bandage, Kerlix, sterile 4.5in	SG016	item		1		
92	bandage, Kling, sterile 4in	SG020	item		1		
93	dressing, ear (Glasscock)	SG042	item		1		
94	tape, surgical paper 1in (Micropore)	SG079	inch		48		
95	**EQUIPMENT CLEANING**						
96	pack, cleaning, surgical instruments	SA043	pack		3	1	
97	**Equipment**	**Code**					
98	chair with headrest, exam, reclining	EF008			81	49	
99	suction and pressure cabinet, ENT (SMR)	EQ234			81	49	
100	operating microscope	E30013			81	49	
101	instrument pack, medium ($1500 and up)	EQ138			111	64	
102	mayo stand	EF015				49	
103	fiberoptic exam light	E11006			81		
104	light source	E13122			81		

AMA/Specialty Society RVS Update RUC
Summary of Recommendations
Originated from the Five-Year Review – Codes Frequently Reported Together Screen

February 2010

CT Abdomen/CT Pelvis

CPT codes 74150, 74160, and 74170 were identified by the RUC's Five-Year Review Identification Workgroup as potentially misvalued through its Codes Frequently Reported Together screening mechanism, as combinations of these codes and codes that describe CT of the pelvis 72192, 72193 and 72194 are reported together more than 95% of the time. To address its concerns, the RUC recommended that the services be referred to the CPT Editorial Panel to create new bundled services of the CT of abdomen and pelvis.

74176 Computed tomography, abdomen and pelvis; without contrast material
The RUC reviewed the survey data for this service and agreed that the physician time (Pre-5 minutes, Intra-22 minutes, Post-5 minutes) is representative of the overall service. However, the RUC found that the respondents overstated the physician work required to perform this combined service. The RUC determined that an appropriate value for this service could be developed by comparing this service to 74182 *Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)* (Work RVU=1.73) which has a similar intra-service time, 20 minutes. The RUC also considered that any application of a multiple procedure reduction would not have resulted in a work value of less than 1.74 work RVUs. (The full value of 74150 *Computed tomography, abdomen; without contrast material* (Work RVU=1.19) plus half the value of 72192 *Computed tomography, pelvis; without contrast material* (1/2 Work RVU=0.55) equals 1.74 work RVUs). The RUC understands that the current combination of 74150 and 72192 results in a total work RVU of 2.28 and 1.74 work RVUs reflects a significant reduction. However, in comparing the value to other services across the RBRVS, including new patient evaluation and management services the RUC determined that 1.74 Work RVUs was appropriate. **The RUC recommends 1.74 Work RVUs for 74176.**

74177 Computed tomography, abdomen and pelvis; with contrast material
The RUC reviewed the survey data for this service and agreed that the pre-service time and post-service time were over-estimated. The RUC reduced the pre-service time and post-service time to 5 minutes each. The specialty society and RUC agreed that the intra-service physician time of 25 minutes is representative of the service. The RUC agreed that the best way to value 74177 was to determine an appropriate add-on for "with contrast". The RUC reviewed the incremental difference between 74150 *Computed tomography, abdomen; without contrast material* (Work RVU=1.19) and 74160 Computed tomography, abdomen; with contrast material(s) (Work RVU=1.27)

(1.27-1.19=0.08 RVUs). The RUC applied this increment to 74176 (Proposed Work RVU=1.74) to develop a work RVU for this service. The resulting work RVU is 1.82 Work RVUs. This proposed value for the surveyed code is further supported by 72198 *Magnetic resonance angiography, pelvis, with or without contrast material(s)* (Work RVU=1.80) which has a similar total service time of 38 minutes as compared to 40 minutes for 74177. The RUC understands that the current combination of 74160 and 72193 results in a total work RVU of 2.43 and 1.82 Work RVUs reflects a significant reduction. However, in comparing the value to other services across the RBRVS, including new patient evaluation and management services, the RUC determined that 1.82 Work RVUs was appropriate. **The RUC recommends 1.82 Work RVUs for 74177.**

74178 Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions

The RUC reviewed the survey data for this service and agreed that the pre-service time and post-service time were over-estimated. The RUC reduced the pre-service time and post-service time to 5 minutes each . The specialty society and RUC agreed that the intra-service time of 30 minutes is representative of the service. The RUC agreed that the best way to value 74178 was to determine an appropriate increment between 74177 and 74178. The RUC reviewed the incremental difference between 72194 *Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections* (Work RVU=1.22) and 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (Work RVU=1.40), 0.18 RVUs and recognized that this difference best approximated the work variance between 74177 and 74178. Therefore, when applying this increment of work to the proposed value for 74177, 1.82 Work RVUs, it results in 2.00 Work RVUs. The RUC also considered that any application of a multiple procedure reduction would not have resulted in a work value of less than 2.01 work RVUs. (The full value of 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (Work RVU=1.40) plus half the value of 72194 *Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections* (1/2 Work RVU=0.61) equals 2.01 work RVUs). Therefore, the RUC agreed that 2.01 work RVUs accurately reflects the work required to perform this service. This value is further validated by comparing it to MPC code 99233 *Subsequent hospital care, per day, for the evaluation and management of a patient* (Work RVU=2.00) which has the same intra-service time as the surveyed code, 30 minutes. The RUC understands that the current combination of 74170 and 72194 results in a total work relative value of 2.62 and that 2.01 RVUs reflects a significant reduction. However, in comparing the value to other services across the RBRVS, including evaluation and management services, the RUC determined that 2.01 work RVUs was appropriate. **The RUC recommends 2.01 Work RVUs for 74178.**

Practice Expense

The RUC reviewed and approved the practice expense inputs as modified and approved by the PE Subcommittee.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
74175		*Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing*	XXX	1.90 (No Change)

For combinations of CT of the abdomen with CT of the pelvis performed at the same session use the following table. Do not report more than one CT of the abdomen or CT of the pelvis for any session.

Stand Alone Code	74150 CT Abdomen WO Contrast	74160 CT Abdomen W Contrast	74170 CT Abdomen WO/W Contrast
72192 CT Pelvis WO Contrast	74176	74178	74178
72193 CT Pelvis W Contrast	74178	74177	74178
72194 CT Pelvis WO/W Contrast	74178	74178	74178

1209

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●74176	S1	Computed tomography, abdomen and pelvis; without contrast material	XXX	1.74
●74177	S2	with contrast material(s)	XXX	1.82
●74178	S3	without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions (Do not report 74176-74178 in conjunction with 72192-72194, 74150-74170) (Report 74176, 74177, or 74178 only once per CT abdomen and pelvis examination)	XXX	2.01

1210

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:74176 Tracking Number S1 Specialty Society Recommended RVU: **2.00**
Global Period: XXX RUC Recommended RVU: **1.74**

CPT Descriptor: Computed tomography, abdomen and pelvis; without contrast material

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old female presents with 2 days of lower abdominal and pelvic pain. The patient has a low-grade temperature and focal rebound tenderness below the umbilicus. The patient has a history of renal insufficiency. A CT scan of the abdomen and pelvis without intravenous contrast is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

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Description of Pre-Service Work:

- Review the reason for the exam and any pertinent clinical history
- Review any prior imaging studies
- Determine the appropriate CT protocol for the examination, confirm that non-contrast images only are indicated, and communicate that protocol to the CT technologists
- Communicate protocol to CT technologists

Description of Intra-Service Work:

- Supervise acquisition of scout views, prescribe area of coverage and supervise acquisition of axial source image sections
- Review initial and subsequent series of CT image data to assure adequacy of anatomic coverage and assess need for additional sections or reconstruction of thin sections in specific locations
- Supervise reconstruction of coronal and/or sagittal 2-D multiplanar reformatted (MPR) images assess need for oblique or other 2D images
- Typically hundreds of images are acquired and this total can increase to almost double when the source images are reviewed with the various requisite window/level settings
- Axial and multiplanar reformatted images are interpreted using "soft-tissue windows" to provide detailed evaluation of each of the following organs: lower mediastinum, liver, spleen, gallbladder, adrenal glands, kidneys, ureters,

bladder, retroperitoneal soft-tissues, stomach, duodenum, small bowel, appendix, colon, pelvic genito-urinary/reproductive organs, all lymph node chains, major abdominal arterial and venous vasculature, and supporting musculature

- Axial and 2-D reformatted images are interpreted using "bone windows" to assess the skeletal structures, "liver windows" to assess the liver and "lung windows" to assess the lungs
- Compare current findings to previous studies
- Dictate report for the medical record

Description of Post-Service Work:

- Review and sign final report
- Discuss findings with referring physicians

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	Geraldine McGinty, MD, Ezequiel Silva, MD				
Specialty(s):	American College of Radiology				
CPT Code:	74176				
Sample Size:	300	**Resp N:**	76	**Response:** 25.3 %	
Sample Type:	Panel	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	25.00	250.00	**600.00**	1000.00	10000.00
Survey RVW:	1.10	1.95	**2.20**	2.30	3.40
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	12.00	15.00	**22.00**	30.00	45.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 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:	74176	**Recommended Physician Work RVU: 1.74**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**7.00**	**-2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**22.00**		

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**
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
74150	XXX	1.19	**RUC Time**

CPT Descriptor Computed tomography, abdomen; without 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
13133	ZZZ	2.19	**RUC Time**	10,081

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
		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: 35 **% of respondents:** 46.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 74176**	**Key Reference CPT Code: 74150**	**Source of Time RUC Time**
Median Pre-Service Time	5.00	3.00	
Median Intra-Service Time	22.00	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	**32.00**	**20.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.07	3.45
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.77	3.17
Urgency of medical decision making	4.03	3.48
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.87	3.24
Physical effort required	3.24	2.93
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.23	2.86
Outcome depends on the skill and judgment of physician	4.10	3.62
Estimated risk of malpractice suit with poor outcome	3.90	3.34

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.06	2.73
Intra-Service intensity/complexity	4.11	3.45
Post-Service intensity/complexity	3.40	3.13

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ACR convened a panel that included a number of physicians familiar with this service to review the RUC survey data. The society reviewed the survey data in the context of the previously RUC surveyed CT abdomen and CT pelvis codes and recognizes there are efficiencies that occur when these examinations are performed

together as compared to the existing individual abdomen and pelvic CT services. The recommendation of the society is for the median survey times of 5, 22 and 5 minutes of pre, intra and post time, respectively. However, although survey respondents indicated a slight reduction in RVU values as compared to the existing services, we believe that value is too high and are recommending a work value of 2.00 to account for the efficiencies that occur primarily in the pre and post service periods.

Our recommended RVU value falls between the median and 25th percentile survey values and is based primarily on reductions in RVUs in the pre and post service period as compared to the individually reported services. The current survey for the combined service eliminates 1 minute of pre service time and 5 minutes of post service time as compared to separately reporting the existing codes. We believe that the intra service work is essentially additive when the CT abdomen and pelvis services are bundled; however, once the duplications in pre and post service work are accounted for the examination of the pelvis becomes an add-on service with 10 minutes of intra service time. While most diagnostic services are not reported using ZZZ codes, the addition of a pelvis CT in a patient undergoing an abdominal CT is quite similar to the addition of a second fetus in a patient undergoing an obstetrical ultrasound. Code 76802, (Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation) describes reporting the second fetus of a twin gestation in a patient undergoing a complete OB ultrasound examination. Code 76802 has an intra service time of 10 minutes with no pre or post service time and an RVU value of 0.83 RVU. The difference in intra service time between 74176 and 74150 is 10 minutes with an additional 2 minutes of pre service time. The addition of the 0.83 RVU to 74150 supports our recommendation of 2.00 RVU. Additionally the society recommendation of 2.00 RVU represents approximately a 25 percent reduction in RVUs for the CT pelvis.

The most commonly chosen reference service was 74150, CT abdomen without contrast. This service is RUC valued with an RVU of 1.19 and pre, intra and post times of 3, 12 and 5 minutes, respectively. Our panel believes this service was chosen based on the similarity in the nature of the services and the fact that this reference service is one of its components. The greater pre and intra service times are validated by higher values given for 11 of 11 intensity measures. We have indicated pre service package 5 which includes 7 minutes of pre time. This has been reduced to 5 minutes which is consistent with other CT scans performed without contrast and congruent with our survey results.

The Society also considered the rank order of these new combined codes and considers that this code falls appropriately within the family of CT codes including the most recently reviewed CT codes such as CT chest without contrast with an RVU of 1.16 and 15 minutes of intra service time but only includes one anatomic region. Our recommendations also compare favorably to our MPC code 13133 with an RVU value of 2.19 and a total time of 30 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 74150 and 72192

How often do physicians 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? 8685378
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 7417X1 in a one year period is estimated to be 8685378.

Specialty Radiology Frequency 6166617 Percentage 70.99 %

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? 2,895,126 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The RUC database estimates that codes 74150 and 72192 were billed approximately 1,724,509 and 1,681,522, respectively, in 2008. The procedure described by codes 74150 and 72192 will now be reported by the new code 85 percent of the time. The RUC database shows that 71 percent of 74150 is performed by radiology and 71 percent for code 72192.

Specialty Radiology Frequency 2055539 Percentage 70.99 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 75572

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:74177 Tracking Number S2 Specialty Society Recommended RVU: **2.15**

Global Period: XXX RUC Recommended RVU: **1.82**

CPT Descriptor: Computed tomography, abdomen and pelvis; with contrast material

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old female with a history of non-Hodgkins lymphoma presents with flank and abdominal pain. Previous examination(s) demonstrated abnormally enlarged abdominal and retro-peritoneal lymph nodes. A CT scan of the abdomen and pelvis with intravenous contrast is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 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

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Description of Pre-Service Work:

- Review the reason for the exam and any pertinent clinical history including history of contrast allergy, renal insufficiency or other contraindication to IV contrast
- Review any prior imaging studies
- Determine the appropriate CT protocol for the examination, confirm that post-contrast images only are indicated, and communicate that protocol to the CT technologists
- Communicate protocol to CT technologists

Description of Intra-Service Work:

- Supervise insertion of IV catheter and set up of mechanical injector
- Supervise acquisition of scout views and prescribe area to be scanned
- Supervise use of mechanical power injector for administration of a rapid bolus of intravenous contrast during scanning and acquisition of axial source image sections in multiple phases of contrast enhancement
- Supervise monitoring for contrast reaction or contrast extravasation during injection
- Review early, intermediate and delayed phases of CT image data to assure adequacy of anatomic coverage and assess need for additional sections, additional delayed images or reconstruction of thin sections in specific locations

- Supervise reconstruction of coronal and/or sagittal 2-D multiplanar reformatted (MPR) images assess need for oblique or other 2D images
- Typically hundreds of images are acquired and this total can increase to almost double when the source images are reviewed with the various requisite window/level settings
- Axial and multiplanar reformatted images are interpreted in early, intermediate, and delayed phases using "sof tissue windows" to provide detailed evaluation of each of the following organs: lower mediastinum, liver, spleen, gallbladder, adrenal glands, kidneys, ureters, bladder, retroperitoneal soft-tissues, stomach, duodenum, small bowel, appendix, colon, pelvic genito-urinary/reproductive organs, all lymph node chains, major abdominal arterial and venous vasculature, and supporting musculature
- Axial and 2-D reformatted images are interpreted using "bone windows" to assess the skeletal structures, "liver windows" to assess the liver and "lung windows" to assess the lungs
- Compare current findings to previous studies
- Dictate report for the medical record

Description of Post-Service Work:

- Review and sign final report
- Discuss findings with referring physicians

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	Geraldine McGinty, MD, Ezequiel Silva, MD				
Specialty(s):	American College of Radiology				
CPT Code:	74177				
Sample Size:	300	**Resp N:**	78	**Response:** 26.0 %	
Sample Type:	Panel	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	80.00	338.00	**1000.00**	2000.00	10000.00
Survey RVW:	1.27	2.03	**2.40**	2.51	3.20
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	20.00	**25.00**	30.00	50.00

Immediate Post Service-Time:	**6.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
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:	74177	**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:		**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:		**25.00**		

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 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
74160	XXX	1.27	**RUC Time**

CPT Descriptor Computed tomography, abdomen; with contrast material (s)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13133	ZZZ	2.19	**RUC Time**	10,081

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
		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: 39 **% of respondents:** 50.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 74177**	**Key Reference CPT Code: 74160**	**Source of Time RUC Time**
Median Pre-Service Time	5.00	3.00	
Median Intra-Service Time	25.00	15.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**35.00**	**23.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.42	3.72
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.06	3.34
Urgency of medical decision making	4.21	3.78
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.09	3.34
Physical effort required	3.34	2.91
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.70	3.25
Outcome depends on the skill and judgment of physician	4.33	3.75
`stimated risk of malpractice suit with poor outcome	4.03	3.48

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.31	2.97
Intra-Service intensity/complexity	4.28	3.59
Post-Service intensity/complexity	3.51	3.08

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 `ecommendations for the appropriate formula and format.*

The ACR convened a panel that included a number of physicians familiar with this service to review the RUC survey data. The society reviewed the survey data in the context of the previously RUC surveyed CT abdomen and CT pelvis codes and recognizes there are efficiencies that occur when these examinations are performed

together as compared to the existing individual abdomen and pelvic CT services. The recommendation of the society is for the median survey times of 7, 25 and 6 minutes of pre, intra and post time, respectively. Although survey respondents indicated a slight reduction in RVU values as compared to the existing services, we believe that value is too high and are recommending a work value of 2.15 which we believe adequately accounts for the efficiencies that occur primarily in the pre and post service periods.

Our recommended RVU value falls between the median and 25th percentile survey values and is based primarily on reductions in RVUs in the post service period as compared to the individually reported services. The current survey for the combined service eliminates 4 minutes of post service time as compared to separately reporting the existing codes. Our recommended pre service time for this combined service of 7 minutes is concordant with more recently valued CT codes and reflects the amount of pre service review necessary when contrast is to be administered. We believe that the intra service work is essentially additive when the CT abdomen and pelvis services are bundled; however, once the duplications in post service work are accounted for the examination of the pelvis becomes an add-on service with 10 minutes of intra service time. While most diagnostic services are not reported using ZZZ codes, the addition of a pelvis CT in a patient undergoing an abdominal CT is quite similar to the addition of a second fetus in a patient undergoing an obstetrical ultrasound. 76802, (Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation) describes reporting the second fetus of a twin gestation in a patient undergoing a complete OB ultrasound examination. Code 76802 has an intra service time of 10 minutes with no pre or post service time and an RVU value of 0.83 RVU. The difference in intra service time between 74177 and 74160 is 10 minutes with an additional 4 minutes of pre service time and 1 minute of post service time. The addition of the 0.83 RVU to 74160 supports our recommendation of 2.15 RVU. Additionally the society recommendation of 2.15 RVU represents approximately a 25 percent reduction in RVUs for the CT pelvis.

The most commonly chosen reference service was 74160, CT abdomen with contrast. This service is RUC valued with an RVU of 1.27 and pre, intra and post times of 3, 15 and 5 minutes, respectively. Our panel believes this service was chosen based on the similarity in the nature of the services and the fact that this reference service is one of its components. The greater pre and intra service times are validated by higher values given for 11 of 11 intensity measures. We have indicated pre service package 5 which includes 7 minutes of pre time which is consistent with other CT scans performed without contrast and congruent with our survey results.

The Society also considered the rank order of these new combined codes and considers that this code falls appropriately within the family of CT codes including CT chest with contrast with an RVU of 1.24 and 15 minutes of intra service time but only includes one anatomic region. Our recommendations also compare favorably to our MPC code 13133 with an RVU value of 2.19 and a total time of 30 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 74160 and 72193

How often do physicians 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? 10634406
'f the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please xplain the rationale for this estimate. The overall number of services for 7417X2 in a one year period is estimated to be 10,634,406.

Specialty Radiology Frequency 8401182 Percentage 79.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,544,802 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The RUC database estimates that codes 74160 and 72193 were billed approximately 2,280,183 and 2,510,090, respectively, in 2008. The procedure described by code 74160 and 72193 will now be reported by the new code, 7417X2, 74 percent of the time. The RUC database shows that 79 percent of 74160 is performed by radiology and 78 percent for code 72193.

Specialty Radiology Frequency 2800394 Percentage 79.00 %

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 73725

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:74178 Tracking Number S3 Specialty Society Recommended RVU: **2.40**
Global Period: XXX RUC Recommended RVU: **2.01**

CPT Descriptor: Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions.

(Do not report 74176-74178 in conjunction with 72192-72194, 74150-74170)

(Report 74176, 74177, or 74178 only once per CT abdomen and pelvis examination)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male presents with vague flank pain and persistent hematuria on serial urinalyses. There is no history of trauma. A CT scan of the abdomen and pelvis without and with intravenous contrast is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 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

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Description of Pre-Service Work:

- Review the reason for the exam and any pertinent clinical history including history of contrast allergy, renal insufficiency or other contraindication to IV contrast
- Review any prior imaging studies
- Determine the appropriate CT protocol for the examination, confirm that post-contrast images only are indicated, and communicate that protocol to the CT technologists
- Communicate protocol to CT technologists

Description of Intra-Service Work:

Supervise insertion of IV catheter and set-up of mechanical injector

- Supervise acquisition of scout views, prescribe area to be scanned and supervise acquisition of unenhanced axial CT image data
- Review the initial unenhanced series of CT image data to assure adequacy of anatomic coverage and assess need for additional sections, additional delayed images or reconstruction of thin sections in specific locations

- Supervise use of mechanical power injector for administration of a rapid bolus of intravenous contrast during scanning and acquisition of axial source image sections in multiple phases of contrast enhancement
- Supervise monitoring for contrast reaction or contrast extravasation during injection
- Review the early, intermediate and delayed phases of CT image data to assure adequacy of anatomic coverage and assess need for additional sections, additional delayed images or reconstruction of thin sections in specific locations
- Supervise reconstruction of coronal and/or sagittal 2-D multiplanar reformatted (MPR) images assess need fo. oblique or other 2D images
- Typically hundreds of images are acquired and this total can increase to almost double when the source images are reviewed with the various requisite window/level settings
- Axial and multiplanar reformatted images are interpreted in early, intermediate, and delayed phases using "soft-tissue windows" to provide detailed evaluation of each of the following organs: lower mediastinum, liver, spleen, gallbladder, adrenal glands, kidneys, ureters, bladder, retroperitoneal soft-tissues, stomach, duodenum, small bowel, appendix, colon, pelvic genito-urinary/reproductive organs, all lymph node chains, major abdominal arterial and venous vasculature, and supporting musculature
- Axial and 2-D reformatted images are interpreted using "bone windows" to assess the skeletal structures, using "liver windows" to assess the liver and "lung windows" to assess the lungs
- Compare current findings to previous studies
- Dictate report for the medical record

Description of Post-Service Work:

- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2010				
Presenter(s):	Geraldine McGinty, MD, Ezequiel Silva, MD				
Specialty(s):	American College of Radiology				
CPT Code:	74178				
Sample Size:	300	**Resp N:**	89	**Response:** 29.6 %	
Sample Type:	Panel	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	200 00	**500.00**	1000.00	10000.00
Survey RVW:	1.40	2.20	**2.62**	2.80	5.00
Pre-Service Evaluation Time:			**7.00**		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	15.00	20.00	**30.00**	36.00	60.00

Immediate Post Service-Time:	6.00					
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:	74178	**Recommended Physician Work RVU: 2.01**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**7.00**	**-2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Immediate Post Service-Time:	5.00					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	0.00	99291x **0.00**	99292x **0.00**			
Other Hospital time/visit(s):	0.00	99231x **0.00**	99232x **0.00**	99233x **0.00**		
Discharge Day Mgmt:	0.00	99238x **0.0**	99239x **0.0**			
Office time/visit(s):	0.00	99211x **0.00**	12x **0.00**	13x **0.00**	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
74160	XXX	1.27	**RUC Time**

CPT Descriptor Computed tomography, abdomen; with contrast material (s)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13133	ZZZ	2.19	**RUC Time**	10,081

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
		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: 33 **% of respondents:** 37.0 %

TIME ESTIMATES (Median)	**CPT Code: 74178**	**Key Reference CPT Code:** 74160	**Source of Time** **RUC Time**
Median Pre-Service Time	5.00	3.00	
Median Intra-Service Time	30.00	15.00	
Median Immediate Post-service Time	5.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**40.00**	**23.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.41	3.62
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.30	3.58
Urgency of medical decision making	4.26	3.69
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.11	3.20
Physical effort required	3.73	3.12
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.92	3.32
Outcome depends on the skill and judgment of physician	4.54	3.76
stimated risk of malpractice suit with poor outcome	4.31	3.56

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.42	2.94
Intra-Service intensity/complexity	4.58	3.71
Post-Service intensity/complexity	3.58	2.97

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 ACR convened a panel that included a number of physicians familiar with this service to review the RUC survey data. The society reviewed the survey data in the context of the previously RUC surveyed CT abdomen and CT pelvis codes and recognizes there are efficiencies that occur when these examinations are performed

together as compared to the existing individual abdomen and pelvic CT services. The recommendation of the society is for the median survey times of 7, 30 and 6 minutes of pre, intra and post time, respectively. Unlike 74176 and 74177, survey respondents did not believe there was a reduction in work as compared to the existing services; however, we believe that the median value is too high and are recommending a work value of 2.40 which we believe adequately to accounts for the efficiencies that occur primarily in the pre and post service periods. Our recommended RVU value falls between the median and 25th percentile survey values.

The existing codes, which have not been previously RUC surveyed, have total times of 27 and 23 minutes respectively for 74170 (CT abdomen with and without contrast) and 72194 (CT pelvis with and without contrast). Our recommended pre service time for this combined service 74178 of 7 minutes is concordant with more recently valued CT codes and reflects the additional amount of pre service work necessary when contrast is to be administered. Our recommended post service time of 6 minutes is in line with our recommendation for 74177.

We believe that the intra service work is essentially additive when the CT abdomen and pelvis services are bundled. We therefore looked at our recommendations for the 74177 code as well as the RUC surveyed times for 74160 (CT abdomen with contrast) and 72193 (CT pelvis with contrast) in developing our recommendation for the intra service work for 74178. Using rank order analysis, the 5 additional minutes of intra service time for the combined procedure reflects the considerable effort involved when the entire abdomen and pelvis are examined twice, once without contrast and again following contrast administration and supports a larger difference in RVUs between 74177 and 74178 as compared to the difference between 74176 and 74177.

Additionally the society recommendation of 2.40 RVU represents approximately a 20 percent reduction in RVUs for the CT pelvis.

The most commonly chosen reference service was 74160, CT abdomen with contrast. This service is RUC valued with an RVU of 1.27 and pre, intra and post times of 3, 15 and 5 minutes, respectively. Our panel believes this service was chosen based on the similarity in the nature of the services and the fact that this reference service is one of its components. The significantly greater pre and intra service times are validated by higher values given for 11 of 11 intensity measures. We have indicated pre-service package 5 which includes 7 minutes of pre time which is consistent with other CT scans performed without contrast and congruent with our survey results.

The Society also considered the rank order of these new combined codes and considers that this code falls appropriately within the family of CT codes including CT chest with contrast with an RVU of 1.24 and 15 minutes of intra service time but only includes one anatomic region. Our recommendations also compare favorably to our MPC code 13133 with an RVU value of 2.19 and a total time of 30 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility 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) 72192, 72193, 72194, 74150, 74160 and 74170

How often do physicians 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? 4540059
'f the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please xplain the rationale for this estimate. The overall number of services for 7417X3 in a one year period is estimated to be 4540059.

Specialty Radiology Frequency 3132642 Percentage 69.00 %

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? 1,513,353 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The RUC estimates that codes 74170 and 72194 were billed approximately 1,062,542 and 450,811, respectively, in 2008. The procedure described by codes 74170 and 72194 will now be reported by the new code, 7417X3, 90 percent of the time. The RUC database shows that 71 percent of 74170 is performed by radiology and 67 percent for code 72194.

Specialty Radiology Frequency 1044214 Percentage 69.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

'Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 78813

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, abdomen and pelvis; without contrast material

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The ACR utilized a consensus panel process to develop recommended inputs. The ACR Practice Expense Committee was assembled using representatives from each of the ACR sub-specialty Economics Committees, thus assuring a broad representation of all the multiple radiology sub-specialties, general radiology and radiation oncology. Attention was paid to the geographic distribution, practice type (academic, private practice) and practice size of the representatives. This Committee was the final common pathway of all the recommendations that are submitted.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The technologist retrieves prior appropriate imaging exams, verifies orders, reviews the chart to incorporate relevant clinical information and confirms contrast protocol with interpreting MD.

Intra-Service Clinical Labor Activities:

The technologist greets the patient and provides gowning. The technologist provides appropriate pre-service education. The technologist prepares the room and equipment and then prepares and positions the patient. The technologist acquires the images. The technologist escorts the patient from the room. The technologist cleans the room and processes the films and paperwork. The technologist then processes the images for archiving and reviews study with interpreting MD prior to patient discharge.

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 tomography, abdomen and pelvis; with contrast material

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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The technologist greets the patient and provides gowning. The technologist provides appropriate pre-service education. The technologist prepares the room and equipment and then prepares and positions the patient. The technologist acquires the images. The technologist escorts the patient from the room. The technologist cleans the room and processes the films and paperwork. The technologist then processes the images for archiving and reviews study with interpreting MD prior to patient discharge.

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 tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further sections in one or both body regions

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The ACR utilized a consensus panel process to develop recommended inputs. The ACR Practice Expense Committee was assembled using representatives from each of the ACR sub-specialty Economics Committees, thus assuring a broad representation of all the multiple radiology sub-specialties, general radiology and radiation oncology. Attention was paid to the geographic distribution, practice type (academic, private practice) and practice size of the representatives. This Committee was the final common pathway of all the recommendations that are submitted.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The technologist retrieves prior appropriate imaging exams, verifies orders, reviews the chart to incorporate relevant clinical information and confirms contrast protocol with interpreting MD.

Intra-Service Clinical Labor Activities:

The technologist greets the patient and provides gowning. The technologist provides appropriate pre-service education. The technologist prepares the room and equipment and then prepares and positions the patient. The technologist acquires the images. The technologist escorts the patient from the room. The technologist cleans the room and processes the films and paperwork. The technologist then processes the images for archiving and reviews study with interpreting MD prior to patient discharge.

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**74176**	**74177**	**74178**
2	**Meeting Date:February 2010**	**CMS**	**Staff**	**Computed tomography, abdomen and pelvis; without contrast material**	**Computed tomography, abdomen and pelvis; with contrast material**	**Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further**
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Non Facility**	**Non Facility**
4	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**
5	**TOTAL CLINICAL LABOR TIME**	**L041B**	**RT**	**46**	**65**	**90**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L041B**	**RT**	**6**	**7**	**7**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L041B**	**RT**	**40**	**58**	**83**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0**	**0**	**0**
9	**PRE-SERVICE**					
10	**Start: Following visit when decision for surgery or procedure made**					
11	Other Clinical Activity (please specify)					
12	- Retrieve prior appropriate imaging exams, verify orders, review the chart to incorporate relevant clinical information and confirm contrast protocol with interpreting MD	L041B	RT	6	7	7
13	**End: When patient enters office/facility for surgery/procedure**					
14	**SERVICE PERIOD**					
15	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**					
16	Review charts					
17	Greet patient and provide gowning	L041B	RT	3	3	3
18	Obtain vital signs					
19	Provide pre-service education/obtain consent	L041B	RT	2	3	3
20	Prepare room, equipment, supplies	L041B	RT	2	4	4
21	Setup scope (non facility setting only)					
22	Prepare and position patient/ monitor patient/ set up IV	L041B	RT	2	5	5
23	Sedate/apply anesthesia					
24	**Intra-service**					
25	Assist physician in performing procedure					
26	- Acquire images	L041B	RT	20	30	45
27	**Post-Service**					
28	Monitor pt. following service/check tubes, monitors, drains					
29	Clean room/equipment by physician staff	L041B	RT	3	3	3
30	Clean Scope					
31	Clean Surgical Instrument Package					
32	Complete diagnostic forms, lab & X-ray requisitions					
33	Review/read X-ray, lab, and pathology reports					
34	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
35	Discharge day management					
36	Other Clinical Activity (please specify)					
37	- Process for archiving and review study with interpreting MD prior to patient discharge	L041B	RT	8	10	20
38	**End: Patient leaves office**					
39	**POST-SERVICE Period**					
40	**MEDICAL SUPPLIES**		**Unit**			
41	Alcohol swab	SJ053			1	1
42	Angiocatheter	SC002			1	1
43	Band aid	SG021			1	1
44	Betadine swab	SJ043			1	1
45	Drape, sheet	SB014			1	1
46	Extension tubing	SC019			1	1
47	Guaze 2x2	SG053			1	1
48	Gauze 2x2, nonsterile	SG050			1	1
49	Heplock	SC012			1	1
50	IV start kit	SA019			1	1
51	Needle, 20G	SC025			1	1
52	slide sleeve (photo slides): proxy for film jacket	SK076		1	1	1
53	Film, 14 x 17, laser (surrogate for digital archival)	SK098		8	10	23
54	Gloves, non-sterile	SB022			1 pair	1 pair
55	CD	SK016		1	1	1
56	Patient gown, disposable	SB026		1	1	1
57	Table paper	SB036		7ft	7 ft	7 ft

	A	B	C	D	E	F
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**74176**	**74177**	**74178**
2	**Meeting Date:February 2010**	**CMS**	**Staff**	**Computed tomography, abdomen and pelvis; without contrast material**	**Computed tomography, abdomen and pelvis; with contrast material**	**Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast material(s) and further**
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Non Facility**	**Non Facility**
58	Saline	SH065			15 cc	15 cc
59	Syringe, 20cc	SC053			1	1
60	Tape	SG075			6 inches	6 inches
61	syringe, 25ml (MRI power injector)	SC059			1	1
62	Equipment:					
63	CT room	EL007		32	48	63
64	Film alternator	ER029		32	48	63
65	Laser printer	ED032		32	48	63
66						

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five-Year Review – Fastest Growing Screen

April 2010

Ultrasound of Extremity

In October 2008, CPT code 76880 *Ultrasound, extremity, nonvascular, real time with image documentation* (Work RVU = 0.59) was identified through the RUC's Five-Year Identification Workgroup's CMS Fastest Growing Screen had never been surveyed by the RUC. The specialty societies explained that the large growth in utilization was caused by physicians' reporting a focused anatomic-specific ultrasound exam and a comprehensive diagnostic exam using the same CPT code, 76880, despite significant differences in physician work and pratice expense costs. In February 2009, the CPT Editorial Panel deleted 76880 and created two new codes to distinguish between the comprehensive diagnostic ultrasound and the focused anatomic-specific ultrasound.

1241

The specialty provided a clear understanding of each service regarding the physician work, time, and intensity. The RUC recognized and agreed with the compelling evidence that there had been a change in the typical provider, the site of service, and the ultrasound technology had changed due to the advent of portable ultrasound devices. Further, the RUC agreed that the patient population is different, whereas there are more evaluations of musculoskeletal pathology using more advanced ultrasound technology rather than magnetic resonance imaging. Ultrasound provides a high level of diagnostic accuracy as well as the potential for dynamic evaluation while at the same time being a non-invasive modality that involves no radiation.

76881 *Ultrasound, extremity, nonvascular, real-time with image documentation; complete*
The RUC reviewed the survey results from 42 radiologists for CPT code 76881. The RUC agreed with the specialty society's recommendation for physician time of 5 minutes pre-service, 15 minutes intra-service, and 5 minutes post service, as typical of the service provided. These time components maintain appropriate rank order with codes such as the following for 76881:

76856 *Ultrasound, pelvic (nonobstetric), real time with image documentation; complete* (Work RVU=0.69, intra-service time = 20 minutes)
76885 *Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician manipulation)* (Work RVU= 0.74, intra-service time = 20 minutes)
76830 *Ultrasound, transvaginal* (Work RVU = 0.69, intra-service time=20 minutes, total time 28 minutes)
99231 *Subsequent hospital care, per day* (Work RVU = 0.76, intra-service time = 10 minutes, total time 20 minutes)
99307 *Subsequent nursing care, per day* (Work RVU = 0.76, intra-service time = 10 minutes, total time 20 minutes)

The RUC, based on an understanding of the physician work, time, and intensities of each of the comparison codes, agreed that the specialty's 25th percentile survey results reflected the work required to perform 76881. The RUC also agreed on the rank order amongst these other services with the new code and agreed that the work value for 76881 should be 0.72. **The RUC recommends a relative work value for CPT code 76881 of 0.72.**

CPT code 76882 *Ultrasound, extremity, nonvascular, real-time with image documentation;* limited anatomic specific
The RUC reviewed the survey results from 44 radiologists and podiatrists for CPT code 76882. The RUC recognized that there had been a change in the typical patient, site of service, provider, and the ultrasound technology had changed due to the advent of portable ultrasound devices. The RUC also concurred with the specialty society's recommendation for physician time of 5 minutes pre-service, 11 minutes intra-service, and 5 minutes post service, as typical of the service provided. These time components maintain appropriate rank order with codes such as the following for 76882:

93228 *Wearable mobile cardiovascular telemetry with electrocardiographic recording,...*(Work RVU = 0.52, intra-service = 12 minutes, total time = 25 minutes)

93285 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device... (Work RVU = 0.50, intra-service time* (Work RVU = 0.50, intra-service time = 12 minutes, total time = 22 minutes)

99212 *Office or other outpatient visit for the evaluation and management of an established patient* (Work RVU = 0.48, 10 minutes intra-service time, total time 16 minutes)

99407 *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes* (Work RVU = 0.50, intra-service time = 15 minutes)

Based on the comparison of physician work of the above codes, the proper rank order, and differences in intensity between 76881 and 76882, the RUC agreed that the physician work value of 76882 should be 0.50. **The RUC recommends a relative work value of 76882 of 0.50.**

CPT *Assistant* Article
The RUC recommends a CPT *Assistant* article be written to ensure the proper reporting of these two services. It was noted by the RUC that these services should not typically be reported more than once per day.

Work Neutrality
The RUC's recommendation for these two codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

1242

New Technology: The RUC recommends that CPT codes 76881 and 76882 be placed on the new technology list and to review utilization data assumptions

Practice Expense: The RUC reviewed the direct practice expense inputs for 76881 and 76882 and edited the typical equipment used for each service. The RUC understands that 76882 is performed with mobile ultrasound, however the RUC was not able to obtain an invoice for the typical mobile ultrasound unit typically purchased by podiatry. The RUC recommends that AMA staff assist in facilitating this discussion between radiology, podiatry, and CMS.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
A complete ultrasound examination of an extremity (76881) consists of real time scans of a specific joint that includes examination of the muscles, tendons, joint, other soft tissue structures, and any identifiable abnormality. Code 76882 refers to an examination of an extremity that would be performed primarily for evaluation of muscles, tendons, joints, and/or soft tissues. This is a limited examination of the extremity where a specific anatomic structure such as a tendon or muscle is assessed. In addition, the code would be used to evaluate a soft-tissue mass that may be present in an extremity where knowledge of its cystic or solid characteristics is needed. For spectral and color Doppler evaluation of the extremities, use 93925, 93926, 93930, 93931, 93970, or 93971 as appropriate.				
D 76880		~~Ultrasound, extremity, nonvascular, real-time with image documentation~~ (76880 has been deleted. To report ultrasound examination of an extremity, see 76881, 76882)	XXX	N/A
⊖76881	II1	Ultrasound, extremity, nonvascular, real-time with image documentation; complete	XXX	0.72
●76882	II2	limited anatomic specific	XXX	0.50

1243

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:76881 Tracking Number II1 Specialty Society Recommended RVU: **0.81**

Global Period: XXX RUC Recommended RVU: **0.72**

CPT Descriptor: Ultrasound, extremity, nonvascular, real-time with image documentation; complete

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old man presents with sore, swollen ankle which came on gradually over a period of several weeks. He is an avid basketball player, but can no longer play because of the pain. Plain radiographs were negative for fracture. The decision is made to perform a diagnostic ultrasound examination.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Review pertinent clinical information.
- Review any prior applicable imaging studies.

Description of Intra-Service Work:

- Supervision of the sonographer performing the examination, as well as personally scanning the patient to perform dynamic maneuvers and/or confirm the sonographer's impression.
- Detailed evaluation of a specific joint that includes assessment of the muscles, tendons, joint, other soft tissue structures, and any identifiable abnormality.

For example, for the ankle:

1. Evaluation of the lateral structures of the ankle including:
a. The peroneus longus and peroneus brevis tendons for tears, tendinosis, or tenosynovitis. Dynamic imaging is als. performed with circumduction of the ankle to assess for peroneal subluxation in real time.

b. The anterior talofibular ligament, calcaneofibular ligament, and anterior inferior tibiofibular ligament for tears or scarring. Stress maneuvers are performed to evaluate for ligamentous laxity and anterolateral ankle impingement.

2. Evaluation of the medial structures of the ankle including:

a. The posterior tibial, flexor digitorum longus and flexor hallucis longus tendons for tears, tendinosis, or tenosynovitis.
b. The deltoid ligament for tears or scarring.
c. The neurovascular bundle for signs of nerve swelling or compression.

3. Evaluation of the anterior structures of the ankle including:
a. The tibialis anterior tendon for tears, tendinosis, or tenosynovitis.
b. The ankle joint for effusions, synovitis, arthritic changes, and adjacent ganglion cysts.

4. Evaluation of the posterior structures of the ankle including:
a. The Achilles tendon for tears, tendinosis, or peritendinitis.
b. The retrocalcaneal and retroachilles bursa for fluid collections or inflammation.

- A report is dictated for the patient's chart.

Description of Post-Service Work:
- Discuss significant findings with the referring service.
- Review and sign final report.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Geraldine McGinty, MD, Ezequiel Silva, MD, Imran Omar, MD, Timothy Tillo, DPM, Seth A. Rubenstein, DPM, Joesph Zuhosky, MD, Phillip Marion, MD				
Specialty(s):	American College of Radiology, American Podiatric Medical Association, American Academy of Physical Medicine & Rehabilitation				
CPT Code:	76881				
Sample Size:	1415	**Resp N:**	42	**Response:** 2.9 %	
Sample Type:	Panel	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	10.00	**20.00**	80.00	1200.00
Survey RVW:	0.65	0.72	**0.81**	1.35	3.43
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	15.00	**15.00**	30.00	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:	76881	**Recommended Physician Work RVU: 0.72**		
		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
76885	XXX	0.74	**RUC Time**

CPT Descriptor Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician manipulation)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20610	000	0.79	**RUC Time**	5,625,121

CPT Descriptor 1 Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11000	000	0.60	**RUC Time**	124,089

CPT Descriptor 2 Debridement of extensive eczematous or infected skin; up to 10% of body surface

)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:** 14.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 76881**	**Key Reference CPT Code: 76885**	**Source of Time RUC Time**
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	15.00	20.00	
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	
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	**25.00**	**20.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.17	2.67
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	2.83	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.67	3.33
Physical effort required	3.17	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.50	2.67
Outcome depends on the skill and judgment of physician	3.83	3.83
Estimated risk of malpractice suit with poor outcome	2.83	2.83

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	1.83	1.83
Intra-Service intensity/complexity	3.50	3.33
Post-Service intensity/complexity	2.17	2.17

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 Vali Recommendations for the appropriate formula and format.*

The ACR, AAPM and AAPMR convened an expert panel to review the survey data. The societies are recommending the median work value of 0.81 with the median survey times of 5 pre, 15 intra and 5 post. This value and time maintains

appropriate rank order with codes such as 76885 (Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician manipulation)) which has a value of 0.74 and 20 minutes of intra-service time. 76885 is a more anatomically focused examination with a typically more challenging patient hence the longer intra-service time. Code 76885 does typically include physician scanning and manipulation which are also felt to be typical for 76881.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one 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) 76880

How often do physicians 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 Podiatry How often? Sometimes

Specialty Physical Medicine and Rehab How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 128019
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 7688X1 in a one year period is estimated to be 128019.

Specialty Radiology Frequency 113936 Percentage 88.99 %

Specialty Podiatry Frequency 19202 Percentage 14.99 %

pecialty Physical Medicine and Rehab Frequency 294 Percentage 0.22 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 42,673 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The RUC database estimates that code 76880 was billed approximately

213,369 in 2008. We estimate that 20 percent of this frequency will now be reported by code 7688X1. The 2008 Medicare percentage for 26 shows 89 percent for radiology, 2 percent for podiatry (we believe this number should be about 15 percent) and .23 percent for physical medicine and rehab.

Specialty Radiology Frequency 37978 Percentage 88.99 %

Specialty Podiatry Frequency 6400 Percentage 14.99 %

Specialty Physical Medicine and Rehab Frequency 98 Percentage 0.22 %

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? (ie. similar work RVU, and specialty) 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:76882 Tracking Number II2 Specialty Society Recommended RVU: **0.56**
Global Period: XXX RUC Recommended RVU: **0.50**

CPT Descriptor: Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 36-year-old male presents with an acute injury to his Achilles tendon, sustained while playing soccer. No open wounds are noted. X-rays are negative for osseous pathology. Mild erythema and edema are noted at the posterior lower leg. Ultrasound is performed to evaluate the Achilles tendon.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 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

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Description of Pre-Service Work:

- Review pertinent clinical information.
- Review any prior applicable imaging studies.

Description of Intra-Service Work:

- Focused ultrasound evaluation of a specific structure.
- Images are obtained in multiple planes through the specific area of concern e.g. Achilles tendon.
- Documentation of the normal anatomic structure and any pathologic findings is made.
- A report is dictated for the patient's chart.

Description of Post-Service Work:

Discuss significant findings with the referring service.
Review and sign final report.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	Geraldine McGinty, MD, Ezequiel Silva, MD, Imran Omar, MD, Timothy Tillo, DPM, Seth A. Rubenstein, DPM, Joesph Zuhosky, MD, Phillip Marion, MD				
Specialty(s):	American College of Radiology, American Podiatric Medical Association, American Academy of Physical Medicine & Rehabilitation				
CPT Code:	76882				
Sample Size:	1415	**Resp N:**	44	**Response:** 3.1 %	
Sample Type:	Panel	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	10.00	**32.50**	100.00	3000.00
Survey RVW:	0.20	0.56	**0.73**	0.90	3.22
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	**11.00**	19.00	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:	76882	**Recommended Physician Work RVU: 0.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**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:		**11.00**		

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
76536	XXX	0.56	**RUC Time**

CPT Descriptor Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	**RUC Time**	2,526,695

CPT Descriptor 1 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30¦, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11000	000	0.60	**RUC Time**	124,089

CPT Descriptor 2 Debridement of extensive eczematous or infected skin; up to 10% of body surface

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:** 20.4 %

TIME ESTIMATES (Median)	**CPT Code: 76882**	**Key Reference CPT Code: 76536**	**Source of Time RUC Time**
Median Pre-Service Time	5.00	4.00	
Median Intra-Service Time	11.00	10.00	
Median Immediate Post-service Time	5.00	4.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	**21.00**	**18.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.67	2.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.67	2.78
Urgency of medical decision making	3.13	2.88
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.33	3.00
Physical effort required	2.22	2.56
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.56	2.33
Outcome depends on the skill and judgment of physician	3.67	3.33
Estimated risk of malpractice suit with poor outcome	2.67	2.89

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	1.89	2.00
Intra-Service intensity/complexity	3.22	3.22
Post-Service intensity/complexity	2.11	2.22

Additional Rationale and Comments

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 Valu Recommendations for the appropriate formula and format.*

The ACR, APMA and AAPMR convened an expert panel to review the survey data. The societies are recommending the 25th percentile work value of 0.56 with the median survey times of 5 pre, 11 intra and 5 post. This value and time maintains appropriate rank order with codes such as 76536 (Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation) which was reviewed by the RUC in April 2009 and has 0.56 work RVU with 4 minutes of pre time, 10 of intra time and 4 of post.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 76880

How often do physicians 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 Podiatry How often? Commonly

Specialty Physical Medicine and Rehab How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 512085
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 7688X2 in a one year period is estimated to be 512085.

Specialty Radiology Frequency 56329 Percentage 10.99 %

Specialty Podiatry Frequency 245800 Percentage 47.99 %

Specialty Physical Medicine and Rehab Frequency 20483 Percentage 3.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 170,695 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The RUC database estimates that code 76880 was billed approximately 213,369 in 2008. We estimate that 80 percent of this frequency will be reported by 7688X2. The 2008 Medicare precentage for global shows 48 percent for podiatry, 11 percent for radiology and 4 percent for physical medicine and rehab.

Specialty Radiology Frequency 18776 Percentage 10.99 %

Specialty Podiatry Frequency 81933 Percentage 47.99 %

Specialty Physical Medicine and Rehab Frequency 6827 Percentage 3.99 %

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? (ie. similar work RVU, and specialty) 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

	A	B	C	D	E	F	G	H	I
1	AMA/Specialty Society RVS Update Committee Recommendation			76880 (to be deleted)		76881		76882	
2	April 29, 2010 RUC	CMS CODE for 76881	CMS CODE for 76882	Ultrasound, extremity, non-vascular, B-scan and/or real time with image documentation Approved PE Inputs		Ultrasound, extremity, nonvascular, real-time with image documentation; complete		Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific	
3	LOCATION			Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			XXX		XXX		XXX	
5	TOTAL CLINICAL LABOR TIME			48		35		19	
6	TOTAL PRE-SERV CLINICAL LABOR TIME			3		3		3	
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			45		32.0		16.0	
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								
15	Follow-up phone calls & prescriptions								
16	Other Clinical Activity (please specify)								
17	*Retrieve prior images for comparison*	RDMS	MTA	3		3		3	
18	**End:When patient enters office/facility for surgery/procedure**								
19	SERVICE PERIOD								
20	**Start: When patient enters office/facility for surgery/procedure**								
21	**Pre-service services**								
22	Review charts								
23	Greet patient, provide gowning, ensure appropriate medical records are available	RDMS	MTA	3		3		3	
24	Obtain vital signs								
25	Provide pre-service education/obtain consent								
26	Prepare room, equipment, supplies	RDMS	MTA	3		3		3	
27	Setup scope (non facility setting only)								
28	Prepare and position patient/ monitor patient/ set up IV	RDMS	MTA	3		3		3	
29	Sedate/apply anesthesia								
30	**Intra-service**								
31	**Monitor patient -- conscious sedation**								
32	Assist physician in performing procedure/*Acquire images*	RDMS		28		15			
33	**Post-Service**								
34	Monitor pt. following service/check tubes, monitors, drains								
35	Clean room/equipment by physician staff	RDMS	MTA	3		3		3	
36	Clean Scope								
37	Clean Surgical Instrument Package								
38	Complete diagnostic forms, lab & X-ray requisitions								
39	Review/read X-ray, lab, and pathology reports								

1260

	A	B	C	D	E	F	G	H	I
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**76880 (to be deleted)**		**76881**		**76882**	
2	**April 29, 2010 RUC**	**CMS CODE for 76881**	**CMS CODE for 76882**	**Ultrasound, extremity, non-vascular, B-scan and/or real time with image documentation**		**Ultrasound, extremity, nonvascular, real-time with image documentation; complete**		**Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific**	
3	**LOCATION**			**Approved PE Inputs**					
				Non Facility	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
40	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
41	Discharge day management 99238 --12 minutes 99239 --15 minutes								
42	Other Clinical Activity (please specify)								
43	*Process images, complete data sheet, present images and data to the interpreting physician*	RDMS	MTA	5		5		4	
44	**End: Patient leaves office**								
45	**POST-SERVICE Period**								
46	**Start: Patient leaves office/facility**								
47	Conduct phone calls/call in prescriptions								
48	*Office visits:*								
49	*List Number and Level of Office Visits*								
50	99211 16 minutes	16	16						
51	99212 27 minutes	27	27						
52	99213 36 minutes	36	36						
53	99214 53 minutes	53	53						
54	99215 63 minutes	63	63						
55	Other								
56									
57	*Total Office Visit Time*								
58	Other Activity (please specify)								
59	**End: with last office visit before end of global period**								
60	**MEDICAL SUPPLIES**								
61	Aquasonic gel	SJ062	SJ062	60cc		60cc		40cc	
62	Disinfectant	SM012	SM012	10cc		10 cc		10 cc	
63	Film Jacket	no code	no code	1		1			
64	Film, 14x17	SK034	SK034	3		3			
65	Film, 8x10 color	SK038	SK038	2		2			
66	Gloves, non-sterile	SB022	SB022	1		1		1	
67	Patient's wipes	SM021	SM021	2		2		2	
68	Pillow case, disposable	SB037	SB037	1		1		1	
69	Processor chemicals	ED024	ED024	1		1			
70	**Equipment**								
71	Ultrasound room	EL015	EL015	X		32.0			
72	Film alternator	ER029	ER029	X		32			
73	Portable Ultrasound (to be determined)	no code	no code					16.0	
74	Table, power	EF031						16	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five-Year Review – CMS Fastest Growing Screen

April 2010

Computerized Scanning Ophthalmology Diagnostic Imaging

In October 2008, CPT code 92135 *Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral* was identified by the RUC through the CMS Fastest Growing Screen. Following further review, the specialties decided to send this code, in October 2009, to the CPT Editorial Panel to delete CPT code 92135 and create two new codes, 92133 *Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve* and 92134 *Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina* to more accurately describe current clinical practices.

1263

The RUC discussed the utilization assumptions for these new services and agreed that compelling evidence was not needed, as there is a calculated work RVU savings. The deleted code, 92135, describes an imaging service that can be used both unilaterally and bilaterally on patients. For 2010, 0.35 work RVUs were assigned when the service was performed unilaterally and 0.70 work RVUs when the services was performed bilaterally. Under current reporting, 92135 is typically reported bilaterally. Utilizing the newly created codes the following utilization assumptions are understood to be correct: 92133 will gather 35% of the total utilization from 92135, 95% of which will be billed bilaterally, and 92134 will gather the remaining 65% of the total utilization from 92135, 75% of which will be billed bilaterally. Given these assumptions, the resulting RUC recommendations will result in a net 27% reduction in work RVU expenditures.

92133
The RUC reviewed the survey results from 47 ophthalmologists and optometrists for code 92133 and agreed with the specialties that adjustments to the survey physician time components was needed to accurately reflect the surveyed service and the previously RUC valued Key Reference Service, CPT code 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination* (Work RVU=0.50). The RUC agreed that 3 minutes should be added to the standard XXX pre-service time package to accurately account for the physician time required to position the patient, prepare the computer database for the examination and to reflect the pre-service time indicated by the survey respondents. In addition, 2 minutes were added to the survey's

median intra-service time for a total of 10 minutes intra-service physician time. This addition accounts for the physician's interpretation and report of the exam results, which is considered intra-service time, not post service time, which explains the inflated surveyed post service time. The recommended physician times are as follows: 3 minutes pre-service time and 10 minutes intra-service time.

The RUC compared CPT code 92133 to the Key Reference Service 92083 (Work RVU = 0.50, pre-service time= 3 minutes and intra-service time= 10 minutes) and agreed that the two services are similar in physician work and have identical total time of 13 minutes. With this comparison, the RUC agreed that the physician work of 92133 should be valued at 0.50 work RVUs, the survey's 25th percentile. **The RUC recommends 0.50 work RVUs for 92133.**

92134

The RUC reviewed the survey results from 49 ophthalmologists and optometrists for 92134 and agreed with the specialties that adjustments to the survey physician time data was needed to accurately reflect the previously RUC valued visual field examination, CPT code 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30¦, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (Work RVU=0.50). The RUC agreed that 7 minutes should be added to the standard XXX pre-service time package to accurately account for the physician time required to position the patient, prepare the computer database for the examination and to reflect the pre-service time indicated by the survey respondents. In addition, the post service time was negated as the survey's median intra-service time of 10 minutes accurately reflects the physician work of interpreting and reporting the examination results and should not be included as post service time. The recommended physician times are as follows: 7 minutes pre-service time and 10 minutes intra-service time.

The RUC compared CPT code 92134 to the Key Reference Service 92235 *Fluorescein angiography (includes multiframe imaging) with interpretation and report* (Work RVU= 0.81 and total time= 28 minutes) and agreed that these services were different in physician work and the reference code should be valued higher due to the additional total physician time involved in the reference code as compared to the surveyed code,28 minutes and 17 minutes, respectively. The RUC also compared the surveyed service to 92083 and agreed that the two services are similar in physician work. The RUC also discussed that 92134 has very similar physician work compared to 92133 and should be valued the same. Given these comparisons, the RUC agreed that 92134 should have a physician work RVU of 0.50, identical to 92133, and slightly below the survey's 25th percentile. **The RUC recommends 0.50 work RVUs for 92134.**

Practice Expense
Minor changes to the clinical labor were made and accepted by the RUC.

New Technology
The RUC recommends that CPT codes 92133 and 92134 be placed on the new technology list.

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommenda-tion
• 92133	U1	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	XXX	0.50
• 92134	U2	retina (Do not report 92133 and 92134 at the same patient encounter) (92135 has been deleted) (92135 has been deleted) (For scanning computerized ophthalmic diagnostic imaging of the optic nerve and retina, see 92133, 92134)	XXX	0.50
D 92135		~~Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral~~	XXX	N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92133 Tracking Number U1 Specialty Society Recommended RVU: **0.50**

Global Period: XXX RUC Recommended RVU: **0.50**

CPT Descriptor: Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female with elevated intraocular pressure in both eyes. Visual field examinations revealed no evidence of visual field loss attributable to glaucoma. Examination of the nerve fiber layer by optical coherence tomography in both eyes is indicated to look for evidence of retinal nerve fiber layer damage consistent with glaucoma.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The examination is performed with a scanning laser polarimeter controlled by a computer system. The computer must be booted-up with adequate storage capacity, occasionally requiring backup of the existing patient database and archiving of prior scans temporarily stored in a hard disc cache to make room for the patient's data. Once the machine is prepared for the examination the patient's data is entered into the database (or and existing folder opened for patients previously examined). The patient is examined to ensure the ability to fixate with the eye not being scanned.

Description of Intra-Service Work: The scanning head is aligned with the eye to be examined and the other eye instructed to follow a fixation light in order to bring the optic nerve of the eye being examined into position. Focus and brightness are then properly adjusted. Three scans are obtained. Once the images have been processed by the computer, and examined for quality by the physician, they are stored to the hard disc cache. A mean image is displayed and the operator uses t computer pointing device to mark the edge of the optic nerve allowing determination of nerve fiber layer parameters and comparison of the age-corrected normative database. The mean image is then stored to the disc. A printout is then obtained. The physician then evaluates the printouts for the quality of the study, interpretation of the printed data looking for areas of nerve fiber layer loss, significance of differences form the normal database and the clinical correlation with the

patient's other data. If the current study is a follow-up of a previous one, evaluation and change over time and correlation with the new clinical course is done. A report is dictated.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010		
Presenter(s):	Stephen A. Kamenetzky, M.D., Cindie Mattox, M.D., Michael Chaglasian, O.D.		
Specialty(s):	Ophthalmology and Optometry		
CPT Code:	92133		
Sample Size:	225	**Resp N:** 47	**Response:** 20.8 %
Sample Type:	Random **Additional Sample Information:** Random sample of U.S. members from the membership database of both the Academy and the AOA.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	100.00	**400.00**	700.00	2000.00
Survey RVW:	0.40	0.50	**0.55**	0.70	0.92
Pre-Service Evaluation Time:			**3.00**		
Pre-Service Positioning Time:			**2.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	4.50	**8.00**	12.50	40.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38,. 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	92133	**Recommended Physician Work RVU: 0.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**2.00**	**0.00**	**2.00**
Pre-Service Positioning Time:		**1.00**	**0.00**	**1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**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? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92083	XXX	0.50	**RUC Time**

CPT Descriptor Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30¦, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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**	14,267,661

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,020,282

`PT Descriptor 2 Ultrasound, abdominal, real time with image documentation; 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: 17 **% of respondents:** 36.1 %

TIME ESTIMATES (Median)	**CPT Code: 92133**	**Key Reference CPT Code: 92083**	**Source of Time RUC Time**
Median Pre-Service Time	3.00	3.00	
Median Intra-Service Time	10.00	10.00	
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	**13.00**	**13.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.88	3.82
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.12	3.82
Urgency of medical decision making	2.94	3.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.71	3.29
Physical effort required	2.29	2.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.59	3.65
Outcome depends on the skill and judgment of physician	4.29	4.18
Estimated risk of malpractice suit with poor outcome	3.47	3.59

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.65	2.41
Intra-Service intensity/complexity	3.29	3.00
Post-Service intensity/complexity	3.35	2.94

Additional Rationale and Comments

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.*

CPT code 92135 (*Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral)* was first considered by the RUC when the new technology for optical coherence imaging of the posterior segment of the eye was introduced in the late 1990s. The code was valued by the RUC at that time with the typical usage being imaging of the optic nerve to assist in the detection and treatment of glaucoma. The descriptor and valuation were unilateral.

This new code is being presented as a result of the large increase in volume detected for 92135 as part of the Five-Year Review Work Group monitoring process. We indicated to the Work Group that the increase in volume was due to the fact that the test was also being used for the evaluation of the retina as part of the treatment of age-related macular degeneration and diabetes mellitus. Macular degeneration treatment in particular has recently been revolutionized and become more dependent on the results of retinal imaging. An application to split 92135 into two codes was taken to the CPT Editorial Panel to clarify the disease state and which region of the eye was being imaged. This CPT change request was approved and both codes (92133 and 921X2) are being submitted to the RUC for valuation. CPT 92135 will be deleted in 2011.

The AAO and the AOA jointly surveyed 92133 and pooled the results. CPT 92135 was previously valued as **unilateral (WRVU=.35)**. The CPT Editorial Panel revised the descriptor to be surveyed as unilateral or bilateral. There were 47 responses (21% response rate) and 79% felt the vignette was typical. The 25th percentile was 0.50 WRVU with the median .55 WRVU. The median intraservice time (IST) was 8 minutes and the post-service time 10 minutes. The reference code chosen most often was 92083, which was the same code used when 92135 was initially valued in 1998. The value of **92083 (WRVU=.50)** was confirmed in the most recent Five-Year Review. Respondents felt that the mental effort and judgment, technical skill and physical effort and stress required were virtually the same for the new code and the reference code.

An expert consensus panel composed of optometrists and ophthalmologists familiar with the RUC process and the testing reviewed the survey results. One issue that required consideration was that the survey had 10 minutes of post-service work included, most likely for the interpretation and preparation of the report. When the reference code was surveyed as part of the 3rd Five Year Review, the RUC moved the 10 minutes of post-service time into the intra-service period and reduced the post-time to zero. We felt that was logical to do here as well. **Therefore, our final time submission is 3/10/0 minutes.**

When CPT code 92135 was originally valued it was 0.1 RVU per eye higher than the reference code 92083. It was new technology at the time and involved more physician work in performing the test. It also generated a larger volume of data to be interpreted by the physician than 92083. With the refinement of the technology, the physician no longer typically performs the test. However, most of these will be done in both eyes and there is still an increased volume of data to be interpreted. In the aggregate the panel felt that the WRVU for the interpretation and report for the new code was identical to that for 92083. The times were identical as well.

Therefore the panel recommends the 25th percentile WRVU of 0.50 for 92133, a value 28% lower than the current code when used bilaterally.

There are several bilateral eye codes that have work values in this range. CPT 92083 has a value of 0.50. Fundus photography 92250 (RUC reviewed, MPC, WRVU 0.44) also falls in this range. CPT 76700 (RUC, MPC, 3/10/4) has the same total time, same IST and a WRVU of 0.81. CPT 71020 (Chest x-ray) is RUC reviewed MPC with a WRVU of 0.22 despite having only 3 minutes of intra-service time and total time of 5 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.

☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☒ Other reason (please explain) Typically billed with an office visit

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. The MD or OD would bill one of the following visit codes at which time this scan would also be perfomed.

3.	CPT Code	Pre	Intra	Post-	Total Time	Work RVU	Global Period
4.	92002	5	15	5	25	.88	XXX
5.	92004	5	25	10	40	1.82	XXX
6.	92012	5	15	5	25	.92	XXX
7.	92014	5	24	8	37	1.42	XXX
8.	99213	3	15	5	23	.97	XXX

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Using 92135

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Commonly

Specialty Optometry How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4800000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Utilization data from the RUC database

Specialty Ophthalmology Frequency 4080000 Percentage 85.00 %

Specialty Optometry Frequency 720000 Percentage 15.00 %

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? 2,566,613 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate that 35% of total utilization from 92135 will go into this code (95% of which was billed bilaterally and 5% of which is billed unilaterally).

Specialty Ophhthalmology Frequency 2181622 Percentage 85.00 %

Specialty Optometry Frequency 384992 Percentage 15.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar vork RVU, and specialty) 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:92134 Tracking Number U2 Specialty Society Recommended RVU: **0.50**
Global Period: XXX RUC Recommended RVU: **0.50**

CPT Descriptor: Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old male with exudative age-related macular degeneration with the recent history of an intravitreal drug injection. Optical coherence tomography is indicated to evaluate subretinal fluid thickness and intraretinal edema in one eye.

Percentage of Survey Respondents who found Vignette to be Typical: 47%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The instrument is prepared by entering necessary patient identifiers. The patient's fixation ability is assessed. The test procedures are described to the patient.

Description of Intra-Service Work: The patient is positioned in the instrument. The scanner is aligned with the eye to be examined while the other eye follows a fixation light in order to bring the portion of the retina being examined into focus. Once the images have been processed by the computer, the output is displayed to ensure adequate images were obtained. The testing of the fellow eye is performed. The physician evaluates the quality of the study and then interprets the findings. If the current study is a follow-up of a previous one, assessment of change is made and correlation with the clinical course is done. A report is prepared and sent to the requesting physician.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010		
Presenter(s):	Stephen A. Kamenetzky, M.D.,William Mieler, M.D., Michael Chaglasian, O.D.		
Specialty(s):	Ophthalmology and Optometry		
CPT Code:	92134		
Sample Size:	225	**Resp N:** 49	**Response:** 21.7 %
Sample Type:	Random **Additional Sample Information:** Random sample of U.S. members from the membership database of both the Academy and the AOA.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	75.00	**250.00**	700.00	10000.00
Survey RVW:	0.35	0.55	**0.70**	0.81	2.50
Pre-Service Evaluation Time:			**7.00**		
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	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: XXX Global Code

CPT Code:	92134	**Recommended Physician Work RVU: 0.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**0.00**	**7.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**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? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92235	XXX	0.81	**RUC Time**

CPT Descriptor Fluorescein angiography (includes multiframe imaging) with interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
71020	XXX	0.22	**RUC Time**	14,267,661

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76700	XXX	0.81	**RUC Time**	1,020,282

CPT Descriptor 2 Ultrasound, abdominal, real time with image documentation; complete

Other Reference CPT Code	Global	Work RVU	Time Source
92083	XXX	0.50	**RUC Time**

CPT Descriptor Visual field examination, unilateral or bilateral, with interpretation and report; extended examination

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 46.9 %

TIME ESTIMATES (Median)	CPT Code: 92134	Key Reference CPT Code: 92235	Source of Time RUC Time
Median Pre-Service Time	7.00	0.00	
Median Intra-Service Time	10.00	28.00	
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	**17.00**	**28.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.04	4.26
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.91	3.91
Urgency of medical decision making	4.22	4.13
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.96	4.22
Physical effort required	2.70	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.61	4.04
Outcome depends on the skill and judgment of physician	4.26	4.30
Estimated risk of malpractice suit with poor outcome	3.52	3.61

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.39	3.43
Intra-Service intensity/complexity	3.83	4.13
Post-Service intensity/complexity	3.70	3.78

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT code 92135 (*Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral)* was first considered by the RUC when the new technology for optical coherence imaging of the posterior segment of the eye was introduced in the late 1990s. The code was valued by the RUC at that time with the typical usage being imaging of the optic nerve to assist in the detection and treatment of glaucoma. The descriptor and valuation were unilateral.

This new code is being presented as a result of the large increase in volume detected for 92135 as part of the Five-Year Review Work Group monitoring process. We indicated to the Work Group that the increase in volume was due to the fact that the test was also being used for the evaluation of the retina as part of the treatment of age-related macular degeneration and diabetes mellitus. Macular degeneration treatment in particular has recently been revolutionized and become more dependent on the results of retinal imaging. An application to split 92135 into two codes was taken to the CPT Editorial Panel to clarify the disease state and which region of the eye was being imaged. This CPT change request was approved and both codes (92133 and 92134) are being submitted to the RUC for valuation. CPT 92135 will be deleted in 2011.

The AAO and the AOA jointly surveyed 92134 and pooled the results. CPT 92135 was previously valued as **unilateral (WRVU=.35)**. The CPT Editorial Panel revised the descriptor to be surveyed as **"unilateral or bilateral."** There were 49 responses (22% response rate), but only 47% felt the vignette was typical. The **25th percentile was 0.55 WRVU** with the **median .70 WRVU.** The **median intraservice time (IST**) was **10 minutes and the post-service time also 10 minutes.** The reference code chosen most often was 92235 (*fluorescein angiography (includes multiframe imaging) with interpretation and report)*. The value of **92235 (WRVU=.81**) was confirmed in the most recent Five-Year Review. Respondents felt that the mental effort and judgment, technical skill and physical effort and stress required were the same or slightly lower for the new code when compared with **the reference code.**

A consensus panel composed of ophthalmologists and optometrists familiar with the RUC process and the service being reviewed analyzed the survey results. Several issues emerged. The survey had 10 minutes of post-service work included, most likely for the interpretation and preparation of the report. When 92083 (the reference code chosen for the other new code in this family, 92133) was surveyed as part of the 3rd Five Year Review, the RUC moved the 10 minutes of post-service time into the intra-service period and reduced the post-time to zero. We felt that the interpretation and report preparation were logically part of the intraservice time. We have done the same thing here. Therefore, our final time submission is **7/10/0 minutes**.

A second, more critical issue was the response that the vignette was felt typical by only 47% of those surveyed. Problems with the vignette were anticipated after CPT required that the descriptor indicate "unilateral or bilateral." The typical patient is for an age-related macular degeneration (AMD) retreatment and we were obligated under RUC rules to use a unilateral example for a code with a "unilateral or bilateral" descriptor Comments from those who felt the vignette not typical indicated that many of the patients had bilateral testing for AMD to monitor the disease in the fellow eye. In addition, there were also a significant number of physicians for whom diabetic retinopathy was the condition of the typical patient. This was especially true in the younger or non-Medicare population. These patients are almost always tested bilaterally and are increasing in frequency because the treatment modalities used for AMD are being used in diabetics for treatment of macular edema and proliferative retinopathy.

The choice of the reference code for 92134 also added complications. CPT 92235, the selected reference code, is a unilateral code requiring review of an extensive amount of digital data (more than for 92134). The panel felt that the work for the reference code was greater than for 92134 when 92134 was performed unilaterally. The consensus panel felt that CPT 92083, the reference code chosen for 92133, was more appropriate in terms of time (3/10/0) and intensity for this service. CPT 92083 was RUC confirmed during the last Five-Year review with a WRVU of 0.50 with a "unilateral or bilateral" CPT descriptor. The typical patient for both 92083 and 92133 however is bilateral.

The panel then used magnitude estimation to compare the work of 92083 and 92134. As the vignette assumed unilateral use, we started with a base WRVU of half of the 92083 value (0.25). The panel also felt that there was more data needing review for 92134 than 92083. The intensity, complexity, stress and iatrogenic risk were also higher because the risk of severe vision loss is immediate in a patient undergoing 92134 testing whereas glaucoma is a disease that progresses more slowly The panel estimated that the additional work at about 25%. **This unilateral service would yield a work RVU of 0.34.** This is about the same as the current value of 92135 (0 35), a unilateral procedure, and is well below the survey 25th percentile value of 0.55 WRVU.

We are proposing that the RUC further consider that the nature of the typical patient for whom this test is ordered is variable enough that the vignette did not accurately capture the frequency of bilateral testing. We therefore propose that the typical patient be 1.5 eyes. There would be no additional pre-service or post service time. The work RVU would be .50 RVU. This value is at the 25th percentile for the survey, captures the increased intensity of this test when compared with 92083 and is 0.20 RVU below the current value of 92135 for bilateral testing.

There are several bilateral eye codes that have work values in this range. CPT 92083 has a value of 0 50. Fundus photography 92250 (RUC reviewed, MPC, WRVU 0.44) also falls in this range. CPT 76700 (RUC, MPC, 3/10/4) has the same total time, same IST and a WRVU of 0.81. CPT 71020 (Chest x-ray) is RUC reviewed MPC with a WRVU of 0.22 despite having only 3 minutes of intra-service time and total time of 5 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain) Typically billed with an office visit

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. The MD or OD would bill one of the following visit codes at which time this scan would also be perfomed.

	CPT Code	Pre	Intra	Post-	Total Time	Work RVU	Global Period
3.							
4.	92002	5	15	5	25	.88	XXX
5.	92004	5	25	10	40	1.82	XXX
6.	92012	5	15	5	25	.92	XXX
7.	92014	5	24	8	37	1.42	XXX
8.	99213	3	15	5	23	.97	XXX

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Using 92135

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Commonly

Specialty Optometry How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 12000000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Strictly an estimate as there is no national frequency data of which we are aware.

Specialty Ophthalmology Frequency 10800000 Percentage 90.00 %

Specialty Optometry Frequency 1200000 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? 4,766,568 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate that 65% of total utilization from 92135 will go into this code (75% of which was billed bilaterally and 25% billed unilaterally).

Specialty Ophhthalmology Frequency 4289912 Percentage 90.00 %

Specialty Optometry Frequency 476657 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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 92083

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:
Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The Academy utilizes a work group comprised of clinical staff familiar with the services from both private and academic clinical settings. Input from clinical staff is reviewed and discussed by a consensus committee of the Academy's Health Policy Committee comprised of ophthalmologists 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 ophthalmic technician reviews the chart to make sure all information is updated and accurate prior to seeing the patient. The examination is performed with a scanning laser polarimeter controlled by a computer system. The computer must be booted-up with adequate storage capacity, occasionally requiring backup of the existing patient database and archiving of prior scans temporarily stored in a hard disc cache to make room for the patient's data. Once the machine is prepared for the examination the patient's data is entered into the database (or and existing folder opened for patients previously examined). The patient is examined to ensure the ability to fixate with the eye not being scanned.

Intra-Service Clinical Labor Activities:

The technician then proceeds to bring patient in exam room and explains test to the patient and informs him/her that the test will take approximately 10 minutes. The scanning head is aligned with the eye to be examined and the other eye instructed to follow a fixation light in order to bring the optic nerve of the eye being examined into position. Focus and brightness are then properly adjusted. Three scans are obtained. Once the images have been processed by the computer, and examined for quality by the physician, they are stored to the hard disc cache. A mean image is displayed and the operator uses the computer pointing device to mark the edge of the optic nerve allowing determination of nerve fiber layer parameters and comparison of the age-corrected normative database. The mean image is then stored to the disc. A printout is then obtained.

Post-Service Clinical Labor Activities:

Once the test is completed, the technician prints the test and attaches it to the patient's chart and brings the patient to the waiting room. The technician ensures that the scanning instrument is cleaned with rubbing alcohol.

	A	B	C	D	E	F	G
1							
2	**AMA/Specialty Society RVS Update Committee**			**92133**		**92134**	
3	**Meeting Date: April 2010**			**Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve**		**Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina**	
4	**LOCATION**	**CMS Code**	**Staff Type**	**Non Facility**	**Facility**	**921x2**	**Facility**
5	**GLOBAL PERIOD**			**xxx**	**xxx**	**xxx**	**xxx**
6	**TOTAL CLINICAL LABOR TIME**			**15.0**	**0.0**	**15.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**2.0**	**0.0**	**2.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**13.0**	**0.0**	**13.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms	L038A	COMT/COT/RN/CST	**2**		**2**	
13	Coordinate pre-surgery services						
14	Schedule space and equipment in facility						
15	Provide pre-service education/obtain consent						
16	Follow-up phone calls & prescriptions						
17	Other Clinical Activity (please specify)						
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	Greet Patient and Provide Gowning, Ensure Appropriate Medical Records Are Available						
23	Obtain vital signs						
24	Provide pre-service education/obtain consent						
25	Prepare room, equipment, supplies	L038A	COMT/COT/RN/CST	**2**		**2**	
26	Setup scope (non facility setting only)						
27	Prepare and position patient/ monitor patient/ set up IV	L038A	COMT/COT/RN/CST	**2**		**2**	
28	Sedate/apply anesthesia						
29	**Intra-service**						
30	Assist physician in performing procedure	L038A	COMT/COT/RN/CST	**6**		**6**	
31	**Post-Service**						
32	Monitor pt. following service/check tubes, monitors, drains						
33	Clean room/equipment by physician staff	L038A	COMT/COT/RN/CST	**3**		**3**	
34	Clean Scope						
35	Clean Surgical Instrument Package						
36	Complete diagnostic forms, lab & X-ray requisitions						
37	Review/read X-ray, lab, and pathology reports						
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
39	Discharge day management 99238 --12 minutes						
40	Other Clinical Activity (please specify)						
41	**End: Patient leaves office**						
42	**POST-SERVICE Period**						
43	**Start: Patient leaves office/facility**						
44	Conduct phone calls/call in prescriptions						
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							
54	*Total Office Visit Time*			**0**	**0**	**0**	**0**
55	Other Activity (please specify)						
56	**End: with last office visit before end of global period**						
57	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**				
58				**None**			
59							
60							
61	**Equipment**	**CMS Code**					
62	Scanning laser device $80K	EQ237		**13.0**		**13.0**	
63	Lane, screening	EL006		**13.0**		**13.0**	
64							

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five Year Review - Harvard Valued - Utilization over 100,000 Screen

April 2010

External Cardiovascular Device Monitoring

CPT Codes 93224, 93227, 93230, 93233 and 93237 were identified by the Five-Year Review Identification Workgroup's Harvard Valued – Utilization over 100,000 Screen. ~~Further,~~ CMS in the 2009 Final Rule asked the RUC to assess the work valuation of CPT code 93230 and 93233, which are used to report 24 hours of cardiac monitoring, because these services have the same work RVU of 0.52 as codes 93268 and 93272, which are used to report 30 days of cardiac event monitoring. To address the Five-Year Review Identification Workgroup's Screen and the CMS request, the specialty society submitted a coding proposal to address the ambiguity in the current family of external monitoring codes by adding introductory language, deleting codes, revising the current descriptors to reflect the new technology utilized and grouping the family of codes into three families: 1.) Holter monitoring codes for recording up to 48 hours (93224-93227), 2.) Mobile cardiovascular telemetry codes (93228-93229) and 3.) Event monitoring codes (93268-93272).

1289

Holter Monitoring Codes

The descriptors of the holter monitoring codes were changed to reflect 48 hours of monitoring rather than 24 hours of monitoring to reflect the current practice of the physician being able to select a 24 hour monitor and a 48 hour monitor. The specialty society estimates that the 48 hour monitor will be selected one-third of the time by the physician. There is only one work Summary of Recommendation form for this family of four codes, one which describes the global, one which describes the professional, and two which describe components of the technical component.

93224 External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, physician review and interpretation

93227 physician review and interpretation

The RUC reviewed the survey data from 49 cardiologists and electrophysiologists for 93224 and agreed that the service times are appropriate. The RUC reviewed the surveyed code in comparison to the reference code 93283 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed*

values with physician analysis, review and report; dual lead implantable cardioverter-defibrillator system (Work RVU=1.15) and noted that the surveyed code has less total service time associated with it as compared to the reference code 24 minutes and 33 minutes respectively. Further, the RUC agreed that the reference code requires significantly more mental effort and judgment, technical skill and physical effort to perform in comparison to the surveyed code. Although the survey median for this service is 0.75 work RVUs, the specialty society agreed that there was no compelling evidence to change the value of this service. Therefore, the specialty recommends and the RUC agrees 0.52 Work RVUs accurately reflects the amount of work it requires to perform this service. **The RUC recommends 0.52 Work RVU for 93224 and 93227.**

Mobile Cardiovascular Telemetry Codes

The mobile cardiovascular telemetry codes (93228-93229) were created and valued in 2008 and there was only a single word changed from "wearable" to "external" in the work descriptor. **The specialty agrees and the RUC recommends that the changes made to these services are editorial.**

Event Monitoring Codes

The event monitoring codes, 93268-93272, describe 30 day cardiac event monitoring. The revisions made to the descriptors for these codes are quite extensive and effectively clarify the reporting of the codes. Although a far less commonly used set of codes (93012 and 93014) was folded into this family of codes, 93012 and 93014 had the same values as the codes in the family. The specialty believes that the changes are editorial in nature. However, since the specialty did complete a survey, they have included the data as it is more current than that from the original valuation in 1994. There is only one work Summary of Recommendation form for this family of four codes, one which describes the global, one which describes the professional, and two which describe components of the technical component.

1290

93268 External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days; includes transmission, physician review and interpretation

93272 physician review and interpretation

The RUC reviewed the survey data for 93268 and agreed that the service times are appropriate. The RUC reviewed the surveyed code in comparison to the reference code 93283 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead implantable cardioverter-defibrillator system* (Work RVU=1.15) and noted that the surveyed code has less total service time associated with it as compared to the reference code 30 minutes and 33 minutes, respectively. Further, the RUC agreed that the reference code

requires significantly more mental effort and judgment, technical skill and physical effort to perform in comparison to the surveyed code. Although the survey median for this service is 1.00 work RVUs, the specialty society agreed that there was no compelling evidence to change the value of this service and agreed that the modifications to this service were editorial. Therefore, the specialty recommends and the RUC agrees 0.52 Work RVUs accurately reflects the amount of work it requires to perform this service. **The RUC recommends 0.52 Work RVU for 93268 and 93272.**

Work Neutrality: The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense – The specialty society recommends and the RUC agrees that the current inputs for these services be maintained.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Codes 93040-93042 are... ~~Cardiovascular monitoring services are diagnostic medical procedures using in-person and remote technology to assess cardiovascular rhythm (ECG) data.~~ ~~***Attended surveillance*** is the immediate availability of a remote technician to respond to rhythm or device alert transmissions from a patient, either from an implanted or wearable monitoring or therapy device, as they are generated and transmitted to the remote surveillance location or center.~~ ~~**Electrocardiographic rhythm derived elements:** elements derived from recordings of the electrical activation of the heart including, but not limited to heart rhythm, rate, ST analysis, heart rate variability, T-wave alternans.~~ ~~***Mobile cardiovascular telemetry (MCT)*** continuously records the electrocardiographic rhythm from external electrodes placed on the patient's body. Segments of the ECG data are automatically (without patient intervention) transmitted to a remote surveillance location by cellular or landline telephone signal. The segments of the rhythm, selected for transmission, are triggered automatically (MCT device algorithm) by rapid and slow heart rates or by the patient during a symptomatic episode. There is continuous real time data analysis by				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
~~preprogrammed algorithms in the device and attended surveillance of the transmitted rhythm segments by a surveillance center technician to evaluate any arrhythmias and to determine signal quality. The surveillance center technician reviews the data and notifies the physician depending on the prescribed criteria.~~ ~~ECG rhythm derived elements are distinct from physiologic data, even when the same device is capable of producing both. Implantable cardiovascular monitor (ICM) device services are always separately reported from Implantable cardioverter-defibrillator (ICD) service.~~ *For other services...* *(For echocardiography, see 93303-93350)* *(For electrocardiogram, 64 leads or greater, with graphic presentation and analysis, see 0178T-0180T)*				
D 93012		~~Telephonic transmission of post-symptom electrocardiogram rhythm strip(s), 24-hour attended monitoring, per 30-day period of time; tracing only~~	XXX	N/A
D 93014		~~physician review with interpretation and report only~~ ~~(Do not report 93014 in conjunction with 93228, 93229)~~ (93012, 93014 have been deleted. To report telephonic transmission of post-symptom electrocardiogram rhythm strips, see 93268-93272)	XXX	N/A
Cardiovascular Monitoring Services Cardiovascular monitoring services are diagnostic medical procedures using in-person and remote technology to assess cardiovascular rhythm (ECG) data. Holter monitors (93224-93227) include up to 48 hours of continuous recording. Mobile cardiac telemetry monitors (93228-93229) have the capability of transmitting a tracing at any time, always have internal ECG analysis algorithms designed to detect major arrhythmias, and transmit to an attended surveillance center. Event monitors (93268-93272) record segments of ECGs triggered either by patient activation or by an internal automatic, pre-programmed detection algorithm (or both) and transmit the recorded				

1292

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
electrocardiographic data when requested (but cannot transmit based upon the sensed rhythm) and do not require attended surveillance. ***Attended surveillance:*** is the immediate availability of a remote technician to respond to rhythm or device alert transmissions from a patient, either from an implanted or wearable monitoring or therapy device, as they are generated and transmitted to the remote surveillance location or center. ***Electrocardiographic rhythm derived elements:*** elements derived from recordings of the electrical activation of the heart including, but not limited to heart rhythm, rate, ST analysis, heart rate variability, T-wave alternans. ***Mobile cardiovascular telemetry (MCT):*** continuously records the electrocardiographic rhythm from external electrodes placed on the patient's body. Segments of the ECG data are automatically (without patient intervention) transmitted to a remote surveillance location by cellular or landline telephone signal. The segments of the rhythm, selected for transmission, are triggered automatically (MCT device algorithm) by rapid and slow heart rates or by the patient during a symptomatic episode. There is continuous real time data analysis by preprogrammed algorithms in the device and attended surveillance of the transmitted rhythm segments by a surveillance center technician to evaluate any arrhythmias and to determine signal quality. The surveillance center technician reviews the data and notifies the physician depending on the prescribed criteria. ECG rhythm derived elements are distinct from physiologic data, even when the same device is capable of producing both. Implantable cardiovascular monitor (ICM) device services are always separately reported from Implantable cardioverter-defibrillator (ICD) service.				
▲93224	PP1	External ~~Wearable~~ electrocardiographic ~~rhythm derived monitoring~~ recording ~~for 24 hours~~ up to 48 hours by continuous ~~original waveform~~ rhythm recording and storage~~, with visual superimposition scanning~~; includes recording, scanning analysis with report, physician review and interpretation	XXX	0.52 (No Change)
▲93225	PP2	recording (includes connection, recording, and disconnection)	XXX	N/A

1293

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲93226	PP3	scanning analysis with report	XXX	N/A
▲93227	PP4	physician review and interpretation (Do not report 93224 in conjunction with 93225, 93226, 93227) (For less than 24 hours of continuous recording, use modifier 52)	XXX	0.52 (No Change)
▲93228	PP5	External~~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 *(Report 93228 only once per 30 days)* (Do not report 93228 in conjunction with 93224, 9322793014)	XXX	0.52 (No Change)
▲93229	PP6	technical support for connection and patient instructions for use, attended surveillance, analysis and physician prescribed transmission of daily and emergent data reports *(Report 93229 only once per 30 days)* (Do not report 93229 in conjunction with 93224-9322693014) (For external ~~wearable~~ cardiovascular monitors that do not perform automatic ECG triggered transmissions to an attended surveillance center, see 93224-93227, 93268-93272, ~~93230-93272~~)	XXX	Carrier Priced

1294

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 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	N/A
D 93231		~~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;recording (includes connection, recording, and disconnection)~~	XXX	N/A
D 93232		~~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;microprocessor-based analysis with report~~	XXX	N/A
D 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	N/A
D 93235		~~Wearable electrocardiographic rhythm derived 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; includes monitoring and real-time data analysis with report, physician review and interpretation~~	XXX	N/A
D 93236		~~Wearable electrocardiographic rhythm derived 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~~	XXX	N/A
D 93237		~~Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous computerized monitoring and non-continuous recording, and real-time data analysis~~	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		~~utilizing a device capable of producing intermittent full-sized waveform tracings, possibly patient activated;physician review and interpretation~~ (93230-93237 have been deleted. To report external electrocardiographic rhythm derived monitoring for 24-48 hours, see 93224-93227)		
▲93268	PP7	External ~~Wearable~~ patient and, when performed, auto activated electrocardiographic rhythm derived event recording with ~~pre~~-symptom-related memory loop with remote download capability up to 30 days ~~, 24-hour attended monitoring, per 30 day period of time~~; includes transmission, physician review and interpretation	XXX	0.52 (No Change)
▲93270	PP8	recording (includes connection, recording, and disconnection)	XXX	N/A
▲93271	PP9	~~monitoring, receipt of~~ transmissions~~,~~ download and analysis	XXX	N/A
▲93272	PP10	physician review and interpretation ~~(For postsymptom recording, see 93012, 93014)~~ (For implanted patient activated cardiac event recording, see 33282, 93285, 93291, 93298)	XXX	0.52 (No Change)

1296

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93224 Tracking Number PP1 Specialty Society Recommended RVU: **0.52**

Global Period: XXX RUC Recommended RVU: **0.52**

CPT Descriptor: External electrocardiographic recording for up to 48 hours by continuous rhythm recording and storage, includes recording, scanning analysis with report, physician review and interpretation

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 82-year-old female without known structural heart disease, and a ten-year history of permanent asymptomatic atrial fibrillation with controlled ventricular response presents to the physician's office with daily episodes of near-syncope for the past week

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 2%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

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Description of Pre-Service Work: A decision is reached to place a holter monitor after evaluation of the patient. The rationale for performance of the diagnostic test and other alternatives are explained to the patient and patient's family. Teaching regarding use of the monitoring system is performed including: a) Device connection and measures to ensure adequate electrode contact to improve diagnostic yield, b) Logging diary entries with accurate time during the recording period, c) Methods of disconnection and returning the monitoring system.

Description of Intra-Service Work: The monitoring system is received by the clinic. The data is downloaded and scanning analysis is performed (the process takes up to 2 hours on average). A technician is required to compile and print relevant data and arrhythmias (including logged diary events) to be interpreted by the physician. Scanned arrhythmias meeting "immediate notification criteria" are promptly brought to the physician's attention.

escription of Post-Service Work: The compiled report is reviewed and interpreted by the physician in a final summary eport. Elements of the report requiring physician review include: a) Assessment of heart rate trends (minimum, maximum and average heart rates), b) Number of supra-/ventricular premature beats, c) Presence or absence of supraventricular or ventricular tachycardia, d) Presence or absence of significant pauses/bradyarrhythmias. Logged diary entries are also reviewed by the physician to determine if a correlative symptomatic arrhythmia exists. Findings of the report are

communicated directly to the patient, and to the referring physician if appropriate. Depending on the results of the report, the physician determines whether the patient requires: a) additional pharmacologic therapy, b) additional outpatient follow-up, or c) inpatient hospitalization/urgent clinical intervention. The compiled report is sent to Medical Records for filing/scanning. The final report is also sent to the referring physician's office.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010				
Presenter(s):	R. Christopher Jones, MD, Gregory S. Thomas, MD, MPH				
Specialty(s):	Cardiology/electrophysiology				
CPT Code:	93224				
Sample Size:	587	**Resp N:** 49	**Response:** 8.3 %		
Sample Type:	Panel	**Additional Sample Information:** panel and random sample			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	50.00	**150.00**	250.00	4400.00
Survey RVW:	0.20	0.52	**0.75**	1.00	3.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	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: XXX Global Code

CPT Code:	93224	**Recommended Physician Work RVU: 0.69**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**2.00**	**0.00**	**2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**7.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 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
93283	XXX	1.15	**RUC Time**

CPT Descriptor Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead implantable cardioverter-defibrillator system

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, 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**	384,556

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**	28,292

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: 8 **% of respondents:** 16.3 %

TIME ESTIMATES (Median)	CPT Code: 93224	Key Reference CPT Code: 93283	Source of Time RUC Time
Median Pre-Service Time	2.00	8.00	
Median Intra-Service Time	15.00	15.00	
Median Immediate Post-service Time	7.00	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	**24.00**	**33.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)		(of those that selected Key Reference code)
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.25	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.88	3.25
Urgency of medical decision making	3.38	3.38
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.88	3.25
Physical effort required	1.88	2.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.25	2.38
Outcome depends on the skill and judgment of physician	3.50	3.75
Estimated risk of malpractice suit with poor outcome	3.38	3.63

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.13	2.88
Intra-Service intensity/complexity	3.13	3.50
Post-Service intensity/complexity	3.00	2.88

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.*

group of cardiologists who perform 24 hour external cardiovascular device monitoring (commonly referred to as Holter monitoring) reviewed the survey data and served as an expert review panel. The group noted that there had been extensive changes to the codes described and that several families had been collapsed into one. While there were several different methods of reporting the code, they all had similar work values and times and many physicians had difficulty distinguishing among them.

In preparing the code application, the physicians took the opportunity to change the description of the code to reflect the practice of ordering either a 24 hour or 48 hour Holter monitor. The previous codes had been limited to 24 hours of data and had been valued based on that limit. The new codes allow for a 48 hour reporting. The physicians discussed the service and indicated that 48 hour holters are ordered 1/3 of the time and 24 hour holters are ordered 2/3 of the time. Th physicians believe that the change in work descriptions for this code represents compelling evidence for an increase in tota values for the services reported with the codes.

After determining that there was compelling evidence for a change in values, the group reviewed the data that had been provided by the survey respondents. 49 physicians completed the survey and all of them had extensive experience with the service, with an average of 150 provided in the past year. The median value from the survey was 0.75. The physicians reviewed this value and compared it to the current values. They noted that the value of 0.52 was under the assumption of a 24 hour Holter monitor and did not consider the possibility of a 48 hour Holter. They then reviewed the times and noted that the times reported by the surveyees were higher than those recorded by Harvard. There is 16 minutes total time according to Harvard and 30 minutes total time reported by those that responded to the survey. The members of the panel thought that the pre-time post-time may have been somewhat overstated by the surveyees and recommend a time of 2 minutes pre-time, 15 minutes intraservice time and 7 minutes post time.

The total time of 24 minutes is substantially higher than the current time. The addition of a 48 hour Holter means that in 1/3 of the cases, there is 100% more data to review and interpret. The panel thought that the median work value was well-supported by comparisons to the key reference code 93283, which has 33 minutes of total time and a work value of 1.15. However, the group thought that the most appropriate recommendation would be to increase the work value by one-third to account for the additional data that would need to be reviewed. One-third of 0.52 is 0.17, which is equivalent to a 99211 (nurse visit) or a 93000 (12 lead EKG). The surveyees thought that this increase captured the additional work associated with the review of additional data.

The expert panel recommends a work value of 0.69 for 93224 and for 93227, which is equivalent to the professional component of 93224.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) See attached spreadsheet

How often do physicians 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 How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 748000
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 current Medicare utilization. It has been reduced by 15% to reflect that some portion of 48 hour Holter monitors are now being billed on two consecutive days.

Specialty Cardiology Frequency 598000 Percentage 79.94 %

Specialty Internal Medicine/Family Practice Frequency 140000 Percentage 18.71 %

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? 500,789 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 current Medicare utilization. It has been reduced by 15% to reflect that some portion of 48 hour Holter monitors are now being billed on two consecutive days.

Specialty Cardiology Frequency 367000 Percentage 79.95 %

pecialty Internal Medicine/Family Practice Frequency 92000 Percentage 20.04 %

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? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. Crosswalked to itself - 93224

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:93268 Tracking Number PP7 Specialty Society Recommended RVU: **0.52**

Global Period: XXX RUC Recommended RVU: **0.52**

CPT Descriptor: External patient and auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days; includes transmission, physician review and interpretation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 32-year-old female presents with complaints of a three month history of palpitations and chest discomfort. Episodes occur on an intermittent and unpredictable basis lasting a few seconds to several minutes.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: A decision for event monitoring is made after evaluation of the patient. The rationale for performance of the diagnostic test and other alternatives are explained to the patient and patient's family. Teaching regarding use of the monitoring system is performed including: a) Device connection and measures to ensure adequate electrode contact to improve diagnostic yield, b) Recording of patient-activated events and process of immediate transmission to a remote attended surveillance center during the recording period, c) Methods of disconnection and returning the monitoring system.

Description of Intra-Service Work: Algorithm determined automatic ECG-triggered, symptomatic patient-triggered events or routinely scheduled rhythm recordings are transmitted to a surveillance center. The surveillance center receives and produces a report which are sent to the physicians office, typically during business hours. Arrhythmia events meeting "immediate notification criteria" are promptly brought to the interpreting physician's attention. After business hours, arrhythmia events meeting "immediate notification criteria" are promptly brought to the on-call physician's attentic Services include all transmissions up to 30 days.

Description of Post-Service Work: The compiled report/recordings are reviewed and interpreted by the physician in a final summary report. Elements of the report requiring physician review include: a) Assessment of heart rate trends (minimum,

maximum and average heart rates), b) Number of supra-/ventricular premature beats, c) Presence or absence of supraventricular or ventricular tachycardia, d) Presence or absence of significant pauses/bradyarrhythmias. Algorithm determined automatic ECG-triggered and patient-triggered events are also reviewed by the physician to determine if a correlative symptomatic arrhythmia exists. Findings of the report are communicated directly to the patient, and to the referring physician if appropriate. Depending on the results of the report, the physician determines whether the patient requires: a) additional pharmacologic therapy, b) additional outpatient follow-up, or c) inpatient hospitalization/urgent clinical intervention. The compiled report is sent to Medical Records for filing/scanning. The final report is also sent to the referring physician's office.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2010		
Presenter(s):	R. Christopher Jones, MD, Gregory S. Thomas, MD, MPH		
Specialty(s):	Cardiology/Electrophysiology		
CPT Code:	93268		
Sample Size:	587	**Resp N:** 41	**Response:** 6.9 %
Sample Type:	Panel	**Additional Sample Information:** random + panel	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	50.00	**100.00**	200.00	1450.00
Survey RVW:	0.30	0.69	**1.00**	1.40	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:	5.00	15.00	**15.00**	30.00	100.00

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: XXX Global Code

CPT Code:	93268	**Recommended Physician Work RVU: 0.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Immediate Post Service-Time:	**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
93283	XXX	1.15	**RUC Time**

CPT Descriptor Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead implantable cardioverter-defibrillator system

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	**RUC Time**	2,526,695

CPT Descriptor 1 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30¦, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11721	000	0.54	**RUC Time**	7,382,193

CPT Descriptor 2 Debridement of nail(s) by any method(s); 6 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: 9 **% of respondents:** 21.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 93268**	**Key Reference CPT Code: 93283**	**Source of Time RUC Time**
Median Pre-Service Time	5.00	8.00	
Median Intra-Service Time	15.00	15.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	**30.00**	**33.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

	(of those that selected Key Reference code)	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.67	3.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.56
Urgency of medical decision making	3.67	3.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.11	3.78
Physical effort required	2.22	2.44
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.78	3.22
Outcome depends on the skill and judgment of physician	3.67	4.00
Estimated risk of malpractice suit with poor outcome	3.67	3.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.67	2.89
Intra-Service intensity/complexity	3.22	3.22
Post-Service intensity/complexity	3.22	3.00

Additional Rationale and Comments

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.*

The American College of Cardiology and Heart Rhythm Society created an expert panel to review the RUC survey data for code 93268, which is used to report event monitoring. The group noted that both there were additional codes (93014) that were used to report this service in the past, but that the same work value was in place for both services of 0.52.

The CPT code was changed as part of a larger effort to review external cardiovascular device monitoring codes, which include three categories: mobile cardiovascular telemetry, 48 hour Holter monitoring, and 30 day event monitoring. The group indicated that the changes to mobile cardiovascular telemetry were clearly editorial and that the changes to Holter monitoring were clearly a change in the description of work.

They then reviewed the changes associated with 93268. While there were extensive wording changes, the group indicated that these changes did not impact the work or the practice expense, just made it more clear and avoided potential coding error. While the previous code included a notation about 24 hour attended monitoring, this had never been required for event monitoring and did not impact the physician work or practice expense.

Since a RUC survey was conducted prior to this discussion, the data is presented for review. The group briefly reviewed the data and thought it well-supported the existing values, but felt that there was no indication that the service or the patients had changed substantially in relevance to the patient population as a whole. As such, the group recommends that the service be considered to be an editorial change and that the current values be maintained. The group was uncertain if the RUC preferred to accept the current times as acceptable or to use the times from the survey in place of that.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Service was previously reported using codes 93268-93272 and 93012 and 93014. 93014 would be reported as 93272 as a professional component equivalent and 93012 would be reported as 93271.

How often do physicians 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 How often?

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. Based on current Medicare utilization data and crosswalks

Specialty Cardiology Frequency 31000 Percentage 88.57 %

Specialty Internal Medicine Frequency 4000 Percentage 11.42 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 23,601 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 Medicare utilization data

Specialty Cardiology Frequency 20000 Percentage 86.95 %

Specialty Internal Medicine Frequency 3000 Percentage 13.04 %

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? (ie. simil work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. Should be crosswalked to itself - 93268.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical