

**RUC and RUC HCPAC Review Board
Recommendations
for CPT 1998**

**RUC Meetings:
September 1996, February 1997, and April 1997**

**AMA/SPECIALTY SOCIETY RVS LTDATE PROCESS
RECOMMENDATIONS**

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American Medical Association

Physicians dedicated to the health of America



Grant V. Rodkey, MD
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May 19, 1997

Grant Bagley, MD
Barton McCann, MD
Health Care Financing Administration
C4-03-03
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Grant and Bart:

Attached are the work relative value recommendations developed by the American Medical Association/Specialty Society RVS Update Committee (RUC) for codes that have been added or revised for CPT 1998. We are also submitting recommendations for the remaining issues from the Five-Year Review of the RBRVS.

The total number of coding changes for CPT 1998 that were considered the RUC and the Advisory Committee is 227. This number includes 108 additions, 93 revisions, and 26 deletions. A summary table of all of these relative value recommendations is included, along with more detailed information on each issue.

The RUC has reviewed each of the remaining issues referred to the CPT Editorial Panel during the Five-Year Review of the RBRVS. It is our understanding that coding proposals have or will be submitted for each of these issues for CPT 1999. For 1998, we request that you retain the current relative values for these services. The RUC is also submitting recommendations for sixteen laparoscopy/hysteroscopy codes to correct rank order anomalies that were created during the Five Year Review.

The RUC HCPAC Review Board has reviewed four issues for CPT 1998: Paring, Cutting, and Trimming of Nails; Endoscopic Plantar Fasciotomy; Psychophysiological Therapy Incorporating Biofeedback; and Occupational and Physical Therapy Evaluation. The recommendations for these issues are also attached.

On a personal note, I would like to express my appreciation and gratitude for all that you have contributed to this process during my tenure as the RUC Chair. Your participation in our meetings and your effort to ensure a fair review of the RUC recommendations has been instrumental in the success of this public/private partnership.

Sincerely,

Grant V. Rodkey, MD
Grant V. Rodkey, MD

Enclosures

cc: James G. Hoehn, MD

CPT 1998 RUC Recommendations

19-May-97

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
00548	XXX	R	Feb96	K1	Anesthesia Services	A1	Editorial		15	15	Yes	Yes
01995	XXX	R	Feb96	K1	Anesthesia Services	A2	Editorial		5	5	Yes	Yes
11200	010	R	Feb97	N	Destruction of Lesions	QQ1	Apr97	22	0.69	0.69	Yes	Yes
11201	ZZZ	R	Feb97	N	Destruction of Lesions	QQ2	Apr97	22	0.35	0.35		Yes
15756	090	R	Feb97		Free Muscle Flap		Editorial		33.23	33.23	Yes	Yes
17000	010	R	Feb97	N	Destruction of Lesions	QQ3	Apr97	22	0.59	0.55		Yes
17001	ZZZ	D	Feb97	N	Destruction of Lesions	QQ4	Apr97	22				Yes
17002	ZZZ	D	Feb97	N	Destruction of Lesions	QQ5	Apr97	22				Yes
17003	ZZZ	N	Feb97	N	Destruction of Lesions	QQ6	Apr97	22	0.19	0.15		Yes
17004	ZZZ	N	Feb97	N	Destruction of Lesions	QQ7	Apr97	22	3.05	2.65		Yes
17010	010	D	Feb97	N	Destruction of Lesions	QQ8	Apr97	22				Yes
17100	010	D	Feb97	N	Destruction of Lesions	QQ9	Apr97	22				Yes
17101	ZZZ	D	Feb97	N	Destruction of Lesions	QQ1	Apr97	22				Yes
17104	010	D	Feb97	N	Destruction of Lesions	QQ1	Apr97	22				Yes
17105	010	D	Feb97	N	Destruction of Lesions	QQ1	Apr97	22				Yes
17110	010	R	Feb97	N	Destruction of Lesions	QQ1	Apr97	22	0.67	0.55	Yes	Yes

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
17111	010	N	Feb97	N	Destruction of Lesions	QQ1	Apr97	22	1.5	0.82		Yes
17200	010	D	Feb97	N	Destruction of Lesions	QQ1	Apr97	22				Yes
17201	ZZZ	D	Feb97	N	Destruction of Lesions	QQ1	Apr97	22				Yes
17250	000	R	Feb97	N	Destruction of Lesions	QQ1	Apr97	22	0.5	0.5	Yes	Yes
19120	090	R	Feb97	W	Excision of cyst		Editorial		5.35	5.35	Yes	Yes
20664	090	N	Feb97	Z	Application of Halo	TT1	Apr97	23	7	7		Yes
22818	090	N	Nov96	7	Kyphectomy	AA1	Feb97	25	30	30		Yes
22819	090	N	Nov96	7	Kyphectomy	AA2	Feb97	25	34.5	34.5		Yes
29860	090	N	Feb97	4	Arthroscopy of the Hip	WW	Apr97	25	7.75	7.75		Yes
29861	090	N	Feb97	4	Arthroscopy of the Hip	WW	Apr97	25	9	9		Yes
29862	090	N	Feb97	4	Arthroscopy of the Hip	WW	Apr97	25	9.5	9.5		Yes
29863	090	N	Feb97	4	Arthroscopy of the Hip	WW	Apr97	25	9.5	9.5		Yes
29891	090	N	Feb97	3	Arthroscopy of the Ankle	VV1	Apr97	24	8	8		Yes
29892	090	N	Feb97	3	Arthroscopy of the Ankle	VV2	Apr97	24	8.6	8.6		Yes
32200	090	R	May95	F	Percutaneous Abscess Drainage	K1	Feb97	16	13.1	13.1	Yes	Yes
32201	000	N	May96	F	Percutaneous Abscess Drainage	K2	Feb97	16	8.7	4		Yes
33496	090	N	Nov96	L	Repair of Non-Structural Valve Dysfunction	BB1	Apr97	14	31.5	25.64		Yes
33530	ZZZ	R	May97		Repair of Non-Structural Valve Dysfunction		Apr97	14	5.86	5.86	Yes	Yes
35400	ZZZ	N	Aug96	H	Intraoperative Endovascular Angioscopy	I1	Feb97	15	3	3		Yes

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same as 1997?	RVU as 1997?	MFS?
36215	XXX	R	May97		Coronary Angiography		Apr97	11	4.68	4.68	Yes	Yes	
37195	XXX	N	Nov96	1	Thrombolytic Therapy for Acute Ischemic Stro	HH1	Editorial		0	0		Yes	
37250	ZZZ	R	Feb97		Intravascular Ultrasound		Editorial		1.51	1.51	Yes	Yes	
37251	ZZZ	R	Feb97		Intravascular Ultrasound		Editorial		1.15	1.15	Yes	Yes	
43116	090	R	May97		Partial esophagectomy		Editorial		29.67	29.67	Yes	Yes	
43496	090	R	May97		Free jejunum transfer		Editorial		0	0	Yes	Yes	
43635	ZZZ	R	Aug96	M	Vagotomy	T1	Editorial		2.06	2.06	Yes	Yes	
44625	090	R	Aug96	K	Closure of Colostomy	L1	Feb97	17	12.1	12.1	Yes	Yes	
44626	090	N	Aug96	K	Closure of Colostomy	L2	Feb97	17	21.29	21.29		Yes	
44700	090	N	Feb 96 Aug96	31 S	Intestinal Sling Procedure	C1	Sep96	9	13	13		Yes	
44900	090	R	Feb96	F	Percutaneous Abscess Drainage	K3	Feb97	16	7.86	7.86	Yes	Yes	
44901	000	N	Feb96	S	Percutaneous Abscess Drainage	K4	Feb97	16	7.72	3.38		Yes	
45112	090	R	May97		Proctectomy with Coloanal Anastomosis		Editorial		24.02	24.02	Yes	Yes	
45119	090	N	Aug96	L	Proctectomy with Coloanal Anastomosis	M1	Feb97	18	23.5	23.5		Yes	
47010	090	R	May96	F	Percutaneous Abscess Drainage	K5	Feb97	16	8.75	8.75	Yes	Yes	
47011	000	N	May96	F	Percutaneous Abscess Drainage	K6	Feb97	16	8.5	3.7		Yes	
48510	090	R	May96	F	Percutaneous Abscess Drainage	K7	Feb97	16	11.22	11.22	Yes	Yes	
48511	000	N	May96	F	Percutaneous Abscess Drainage	K8	Feb97	16	10	4		Yes	
49040	090	R	May96	F	Percutaneous Abscess Drainage	K9	Feb97	16	8.74	8.74	Yes	Yes	

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
49041	000	N	May96	F	Percutaneous Abscess Drainage	K10	Feb97	16	8.64	4		Yes
49060	090	R	May96	F	Percutaneous Abscess Drainage	K11	Feb97	16	10.55	10.55	Yes	Yes
49061	000	N	May96	F	Percutaneous Abscess Drainage	K12	Feb97	16	9.31	3.7		Yes
49062	090	N	Nov96	M	Lymphocele Drainage	CC1	Feb97	22	10.78	10.78		Yes
49423	000	N	May96	F	Percutaneous Abscess Drainage	K19	Feb97	16	2.72	1.46		Yes
49424	000	N	May96	F	Percutaneous Abscess Drainage	K18	Feb97	16	0.83	0.76		Yes
49560	090	R	Aug96	Q	Ventral Herniorrhaphy	U1	Editorial		9.48	9.48	Yes	Yes
49565	090	R	Aug96	Q	Ventral Herniorrhaphy	U2	Editorial		9.48	9.48	Yes	Yes
49568	ZZZ	R	Aug96	Q	Ventral Herniorrhaphy	U3	Editorial		4.89	4.89	Yes	Yes
50020	090	R	May96	F	Percutaneous Abscess Drainage	K13	Feb97	16	12.41	12.41	Yes	Yes
50021	000	N	May96	F	Percutaneous Abscess Drainage	K14	Feb97	16	9.39	3.38		Yes
51840	090	R	Feb97	12	Burch Procedure	AK1	Editorial		9.78	9.78	Yes	Yes
52281	000	R	May96	F	Cystourethroscopy	F1	Editorial		2.8	2.8	Yes	Yes
52282	000	N	Nov96	N	Urethral Endoprosthesis	DD1	Feb97	24	6.4	6.4		Yes
53850	090	N	Aug96	I	Transurethral Destruction of Prostate Tissue	J1	Feb97	23	9.58	9.58		Yes
53852	090	N	Feb97	9	Transurethral Destruction of Prostate Tissue	J2	Apr97	26	9.92	9.58		Yes
56304	010	R	Aug96	S	Laparoscopic Surgery	P1	Apr97	10	11.07	10		Yes
56309	010	R	Feb97	13	Laparoscopic Surgery	AL1	Editorial		13.79	13.79	Yes	Yes
56310	090	N	Aug96	S	Laparoscopic Surgery	P2	Feb97	21	13.5	13.5		Yes

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
56314	010	N	Nov96	M	Lymphocele Drainage	CC2	Feb97	22	8.93	8.93		Yes
56318	090	N	Aug96	S	Laparoscopic Surgery	P5	Feb97	21	10.63	10.63		Yes
56345	090	N	Aug96	S	Laparoscopic Surgery	P7	Sep97	27				Yes
56346	090	N	Aug96	S	Laparoscopic Surgery	P3	Feb97	21	7.4	7.18		Yes
56347	090	N	Aug96	S	Laparoscopic Surgery	P4	Sep97	27				Yes
56348	090	N	Aug96	S	Laparoscopy with Intestinal Resection	O1	Feb97	19	20	20		Yes
56349	090	N	Aug96	S	Laparoscopic Surgery	P6	Feb97	21	17.75	17.75		Yes
57308	090	N	Aug96	N	Closure of Rectovaginal Fistula	N1	Feb97	20	9.31	9.31		Yes
57531	090	N	Feb97	18	Radical Trachelectomy	YY1	Apr97	12	28	28		Yes
58152	090	R	Feb97	12	Burch Procedure	AK2	Editorial		14.1	14.1	Yes	Yes
58340	XXX	R	Feb97	P	Hysterosonography	GG2	Editorial	11	0.88	0.88	Yes	Yes
58820	090	R	May96	F	Percutaneous Abscess Drainage	K15	Feb97	16	3.96	3.96	Yes	Yes
58822	090	R	May96	F	Percutaneous Abscess Drainage	K16	Feb97	16	9.06	9.06	Yes	Yes
58823	000	N	May96	F	Percutaneous Abscess Drainage	K17	Feb97	16		3.38		Yes
59050	XXX	R	Feb97	16	Fetal Monitoring	AM1	Editorial		0.89	0.89	Yes	Yes
59051	XXX	R	Feb97	16	Fetal Monitoring		Editorial		0.74	0.74	Yes	Yes
59160	010	R	Feb97	16	Curettage, Postpartum	AN1	Editorial		2.66	2.66	Yes	Yes
59871	000	N	Feb97	19	Removal of Cerclage Suture	ZZ1	Apr97	13	2.13	2.13		Yes
61793	090	R	Nov96	P	Stereotactic Radiosurgery	JJ1	Editorial		16.7	16.7	Yes	Yes

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
67027	090	N	Nov96	S	Ganciclovir Implant	EE1	Apr97	28	10.35	10.35		Yes
70553	XXX	R	Apr97		MI, Brain		Editorial		2.36	2.36	Yes	Yes
74283	XXX	R	Nov96	5	Therapeutic Enema	II1	Editorial		2.02	2.02	Yes	Yes
74740	XXX	R	Feb97	P	Hysterosonography	GG3	Editorial		0.38	0.38	Yes	Yes
75989	XXX	R	May96	F	Percutaneous Abscess Drainage	K20	Feb97	16	1.19	1.19	Yes	Yes
76070	XXX	R	Feb97	20	Bone Density Studies	AB1	Apr97	29	0.25	0.25	Yes	Yes
76075	XXX	R	Feb97	20	Bone Density Studies	AB2	Apr97	29	0.3	0.3	Yes	Yes
76076	XXX	N	Feb97	20	Bone Density Studies	AB3	Apr97	29	0.3	0.22		Yes
76078	XXX	N	Feb97	20	Bone Density Studies	AB4	Apr97	29	0.26	0.2		Yes
76080	XXX	R	May96	F	Percutaneous Abscess Drainage	K21	Feb97	16	0.54	0.54	Yes	Yes
76095	XXX	R	May97		Stereotactic Breast Biopsy		Editorial		1.59	1.59	Yes	Yes
76375	XXX	R	Nov96	U	Medical Holography	KK1	Editorial		0.16	0.16	Yes	Yes
76390	XXX	N	Nov96	T	Magnetic Resonance Spectroscopy	FF1	Apr97	D	1.65	1.4		Yes
76815	XXX	R	Feb97	21	Echography, Pregnant Uterus	AO1	Editorial		0.65	0.65	Yes	Yes
76830	XXX	R	Feb97	P	Hysterosonography		Apr97	11	0.69	0.69	Yes	Yes
76831	XXX	N	Feb97	P	Hysterosonography	GG1	Apr97	11	0.72	0.72		Yes
76885	XXX	N	Nov96	6	Echography of Infant Hip	Z1	Feb97	26	0.74	0.74		Yes
76886	XXX	N	Nov96	6	Echography of Infant Hip	Z2	Feb97	26	0.62	0.62		Yes
77295	XXX	R	Nov96	W	Therapeutic Radiology Simulation-Aided Field	LL1	Editorial		4.57	4.57	Yes	Yes

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
78350	XXX	R	Feb97	20	Bone Density Studies	AB5	Apr97	29	0.22	0.22	Yes	Yes
78351	XXX	R	Feb97	20	Bone Density Studies	AB6	Apr97	29	0.3	0.3	Yes	Yes
78459	XXX	R	May97		PET Myocardial Perfusion Imaging		Apr97	B	1.88	1.88	Yes	Yes
78491	XXX	N	Aug96	T	PET Myocardial Perfusion Imaging	Q1	Apr97	B	1.7	1.5		Yes
78492	XXX	N	Aug96	T	PET Myocardial Perfusion Imaging	Q2	Apr97	B	1.94	1.87		Yes
78707	XXX	R	Aug96	U	Renal Nuclear Medicine	R1	Apr97	C	0.96	0.96		Yes
78708	XXX	N	Aug96	U	Renal Nuclear Medicine	R2	Apr97	C	1.21	1.21		Yes
78709	XXX	N	Aug96	U	Renal Nuclear Medicine	R3	Apr97	C	1.41	1.41		Yes
78710	XXX	R	Feb97		Kidney Imaging		Editorial		0.66	0.66	Yes	Yes
78725	XXX	D	Aug96	U	Renal Nuclear Medicine	R4	Apr97	C				Yes
78726	XXX	D	Aug96	U	Renal Nuclear Medicine	R5	Apr97	C				Yes
78727	XXX	D	Aug96	U	Renal Nuclear Medicine	R6	Apr97	C				Yes
80002		D	Nov96	3	Automated Multichannel Tests		Lab					No
80003		D	Nov96	3	Automated Multichannel Tests		Lab					No
80004		D	Nov96	3	Automated Multichannel Tests		Lab					No
80005		D	Nov96	3	Automated Multichannel Tests		Lab					No
80006		D	Nov96	3	Automated Multichannel Tests		Lab					No
80007		D	Nov96	3	Automated Multichannel Tests		Lab					No
80008		D	Nov96	3	Automated Multichannel Tests		Lab					No

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
80009		D	Nov96	3	Automated Multichannel Tests		Lab					No
80010		D	Nov96	3	Automated Multichannel Tests		Lab					No
80011		D	Nov96	3	Automated Multichannel Tests		Lab					No
80012		D	Nov96	3	Automated Multichannel Tests		Lab					No
80016		D	Nov96	3	Automated Multichannel Tests		Lab					No
80018		D	Nov96	3	Automated Multichannel Tests		Lab					No
80019		D	Nov96	3	Automated Multichannel Tests		Lab					No
80049		N	Nov96	3	Organ Disease Panels		Lab					No
80050		R	Feb97	I	Organ Disease Panels		Lab					No
80058		R	Nov96	3	Organ Disease Panels		Lab					No
80076		N	Nov96	3	Organ Disease Panels		Lab					No
80077		N	Nov96	3	Organ Disease Panels		Lab					No
80201		N	Feb97	22	Topiramate	AP1	Lab					No
82270		R	May96	N	Occult Blood	H1	Lab					No
83019		N	Feb97	25	Breath Test	AQ1	Lab					No
84484		R	Aug96	W	Troponin	V1	Lab					No
84512		N	Aug96	W	Troponin	V2	Lab					No
86148		N	May97	IX	Antiphosphatidylersine		Lab					No
86287		D	May97	M	Immunology/Microbiology		Lab					No

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
86289		D	May97	M	Immunology/Microbiology		Lab					No
86290		D	May97	M	Immunology/Microbiology		Lab					No
86291		D	May97	M	Immunology/Microbiology		Lab					No
86293		D	May97	M	Immunology/Microbiology		Lab					No
86295		D	May97	M	Immunology/Microbiology		Lab					No
86296		D	May97	M	Immunology/Microbiology		Lab					No
86299		D	May97	M	Immunology/Microbiology		Lab					No
86302		D	May97	M	Immunology/Microbiology		Lab					No
86303		D	May97	M	Immunology/Microbiology		Lab					No
86306		D	May97	M	Immunology/Microbiology		Lab					No
86308		R	May97	M	Immunology/Microbiology		Lab					No
86309		R	May97	M	Immunology/Microbiology		Lab					No
86310		R	May97	M	Immunology/Microbiology		Lab					No
86311		D	May97	M	Immunology/Microbiology		Lab					No
86313		D	May97	M	Immunology/Microbiology		Lab					No
86315		D	May97	M	Immunology/Microbiology		Lab					No
86317		R	May97	M	Immunology/Microbiology		Lab					No
86360		R	Feb97	30	CD4 T Lymphocyte Count	AS1	Lab					No
86361		N	Feb97	30	CD4 T Lymphocyte Count	AS2	Lab					No

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
86632		R	May97	M	Immunology/Microbiology		Lab					No
86692		R	May97	M	Immunology/Microbiology		Lab					No
86703		N	May97	M	Immunology/Microbiology		Lab					No
86704		N	May97	M	Immunology/Microbiology		Lab					No
86705		N	May97	M	Immunology/Microbiology		Lab					No
86706		N	May97	M	Immunology/Microbiology		Lab					No
86707		N	May97	M	Immunology/Microbiology		Lab					No
86708		N	May97	M	Immunology/Microbiology		Lab					No
86709		N	May97	M	Immunology/Microbiology		Lab					No
86803		N	May97	M	Immunology/Microbiology		Lab					No
86804		N	May97	M	Immunology/Microbiology		Lab					No
87178		D	May97	M	Immunology/Microbiology		Lab					No
87179		D	May97	M	Immunology/Microbiology		Lab					No
87260		N	May97	M	Immunology/Microbiology		Lab					No
87265		N	May97	M	Immunology/Microbiology		Lab					No
87270		N	May97	M	Immunology/Microbiology		Lab					No
87272		N	May97	M	Immunology/Microbiology		Lab					No
87274		N	May97	M	Immunology/Microbiology		Lab					No
87276		N	May97	M	Immunology/Microbiology		Lab					No

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
87278		N	May97	M	Immunology/Microbiology		Lab					No
87280		N	May97	M	Immunology/Microbiology		Lab					No
87285		N	May97	M	Immunology/Microbiology		Lab					No
87290		N	May97	M	Immunology/Microbiology		Lab					No
87299		N	May97	M	Immunology/Microbiology		Lab					No
87301		N	May97	M	Immunology/Microbiology		Lab					No
87320		N	May97	M	Immunology/Microbiology		Lab					No
87324		N	May97	M	Immunology/Microbiology		Lab					No
87328		N	May97	M	Immunology/Microbiology		Lab					No
87332		N	May97	M	Immunology/Microbiology		Lab					No
87335		N	May97	M	Immunology/Microbiology		Lab					No
87340		N	May97	M	Immunology/Microbiology		Lab					No
87350		N	May97	M	Immunology/Microbiology		Lab					No
87380		N	May97	M	Immunology/Microbiology		Lab					No
87385		N	May97	M	Immunology/Microbiology		Lab					No
87390		N	May97	M	Immunology/Microbiology		Lab					No
87391		N	May97	M	Immunology/Microbiology		Lab					No
87420		N	May97	M	Immunology/Microbiology		Lab					No
87425		N	May97	M	Immunology/Microbiology		Lab					No

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
87430		N	May97	M	Immunology/Microbiology		Lab					No
87449		N	May97	M	Immunology/Microbiology		Lab					No
87450		N	May97	M	Immunology/Microbiology		Lab					No
87470		N	May97	M	Immunology/Microbiology		Lab					No
87471		N	May97	M	Immunology/Microbiology		Lab					No
87472		N	May97	M	Immunology/Microbiology		Lab					No
87475		N	May97	M	Immunology/Microbiology		Lab					No
87476		N	May97	M	Immunology/Microbiology		Lab					No
87477		N	May97	M	Immunology/Microbiology		Lab					No
87480		N	May97	M	Immunology/Microbiology		Lab					No
87481		N	May97	M	Immunology/Microbiology		Lab					No
87482		N	May97	M	Immunology/Microbiology		Lab					No
87485		N	May97	M	Immunology/Microbiology		Lab					No
87486		N	May97	M	Immunology/Microbiology		Lab					No
87487		N	May97	M	Immunology/Microbiology		Lab					No
87490		N	May97	M	Immunology/Microbiology		Lab					No
87491		N	May97	M	Immunology/Microbiology		Lab					No
87492		N	May97	M	Immunology/Microbiology		Lab					No
87495		N	May97	M	Immunology/Microbiology		Lab					No

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
87496		N	May97	M	Immunology/Microbiology		Lab					No
87497		N	May97	M	Immunology/Microbiology		Lab					No
87510		N	May97	M	Immunology/Microbiology		Lab					No
87511		N	May97	M	Immunology/Microbiology		Lab					No
87512		N	May97	M	Immunology/Microbiology		Lab					No
87515		N	May97	M	Immunology/Microbiology		Lab					No
87516		N	May97	M	Immunology/Microbiology		Lab					No
87517		N	May97	M	Immunology/Microbiology		Lab					No
87520		N	May97	M	Immunology/Microbiology		Lab					No
87521		N	May97	M	Immunology/Microbiology		Lab					No
87522		N	May97	M	Immunology/Microbiology		Lab					No
87525		N	May97	M	Immunology/Microbiology		Lab					No
87526		N	May97	M	Immunology/Microbiology		Lab					No
87527		N	May97	M	Immunology/Microbiology		Lab					No
87528		N	May97	M	Immunology/Microbiology		Lab					No
87529		N	May97	M	Immunology/Microbiology		Lab					No
87530		N	May97	M	Immunology/Microbiology		Lab					No
87531		N	May97	M	Immunology/Microbiology		Lab					No
87532		N	May97	M	Immunology/Microbiology		Lab					No

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
87533		N	May97	M	Immunology/Microbiology		Lab					No
87534		N	May97	M	Immunology/Microbiology		Lab					No
87535		N	May97	M	Immunology/Microbiology		Lab					No
87536		N	May97	M	Immunology/Microbiology		Lab					No
87537		N	May97	M	Immunology/Microbiology		Lab					No
87538		N	May97	M	Immunology/Microbiology		Lab					No
87539		N	May97	M	Immunology/Microbiology		Lab					No
87540		N	May97	M	Immunology/Microbiology		Lab					No
87541		N	May97	M	Immunology/Microbiology		Lab					No
87542		N	May97	M	Immunology/Microbiology		Lab					No
87550		N	May97	M	Immunology/Microbiology		Lab					No
87551		N	May97	M	Immunology/Microbiology		Lab					No
87552		N	May97	M	Immunology/Microbiology		Lab					No
87555		N	May97	M	Immunology/Microbiology		Lab					No
87556		N	May97	M	Immunology/Microbiology		Lab					No
87557		N	May97	M	Immunology/Microbiology		Lab					No
87560		N	May97	M	Immunology/Microbiology		Lab					No
87561		N	May97	M	Immunology/Microbiology		Lab					No
87562		N	May97	M	Immunology/Microbiology		Lab					No

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
87562		N	May97	M	Immunology/Microbiology		Lab					No
87580		N	May97	M	Immunology/Microbiology		Lab					No
87581		N	May97	M	Immunology/Microbiology		Lab					No
87582		N	May97	M	Immunology/Microbiology		Lab					No
87590		N	May97	M	Immunology/Microbiology		Lab					No
87591		N	May97	M	Immunology/Microbiology		Lab					No
87592		N	May97	M	Immunology/Microbiology		Lab					No
87620		N	May97	M	Immunology/Microbiology		Lab					No
87621		N	May97	M	Immunology/Microbiology		Lab					No
87622		N	May97	M	Immunology/Microbiology		Lab					No
87650		N	May97	M	Immunology/Microbiology		Lab					No
87651		N	May97	M	Immunology/Microbiology		Lab					No
87652		N	May97	M	Immunology/Microbiology		Lab					No
87797		N	May97	M	Immunology/Microbiology		Lab					No
87798		N	May97	M	Immunology/Microbiology		Lab					No
87799		N	May97	M	Immunology/Microbiology		Lab					No
87810		N	May97	M	Immunology/Microbiology		Lab					No
87850		N	May97	M	Immunology/Microbiology		Lab					No
87880		N	May97	M	Immunology/Microbiology		Lab					No

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
87899		N	May97	M	Immunology/Microbiology		Lab					No
88108	XXX	R	Feb97	31	Cervical or Vaginal Cytopathology	AC1	Apr97	30	0.56	0.56	Yes	Yes
88141	XXX	N	Feb97	31	Cervical or Vaginal Cytopathology	AC2	Apr97	30	0.42	0.42		Yes
88142	XXX	N	Feb97	31	Cervical or Vaginal Cytopathology	AC3	Apr97	30				No
88151	XXX	D	Feb97	31	Cervical or Vaginal Cytopathology	AC4	Apr97	30				Yes
88152	XXX	N	Feb97	31	Cervical or Vaginal Cytopathology	AC5	Apr97	30				No
88157	XXX	D	Feb97	31	Cervical or Vaginal Cytopathology	AC6	Apr97	30				Yes
88158	XXX	N	Feb97	31	Cervical or Vaginal Cytopathology	AC7	Apr97	30				No
89250		R	Feb97	32	Reproductive Laboratory Services	AT1	Lab					No
89251		N	Feb97	32	Reproductive Laboratory Services	AT2	Lab					No
89252		N	May97		Reproductive Laboratory Services	AT3	Lab					No
89253		N	Feb97	32	Reproductive Laboratory Services	AT4	Lab					No
89254		N	Feb97	32	Reproductive Laboratory Services	AT5	Lab					No
89255		N	Feb97	32	Reproductive Laboratory Services	AT6	Lab					No
89256		N	Feb97	32	Reproductive Laboratory Services	AT7	Lab					No
89257		N	Feb97	32	Reproductive Laboratory Services	AT8	Lab					No
89258		N	Feb97	32	Reproductive Laboratory Services	AT9	Lab					No
89259		N	Feb97	32	Reproductive Laboratory Services	AT10	Lab					No
89260		N	Feb97	32	Reproductive Laboratory Services	AT11	Lab					No

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
89261		N	Feb97	32	Reproductive Laboratory Services	AT12	Lab					No
89300		R	May97		Reproductive Labarotory Services	AT13	Lab					No
90748		N	May96	J	Hepatitis B & HIB Vaccine	G1	Lab					No
90801	XXX	R	May97		Psychotherapy	RR1	Apr97	15	2.8	2.8	Yes	Yes
90802	XXX	N	Feb97	Q	Psychotherapy	RR2	Apr97	15	3.01	3.01	Yes	Yes
90804	XXX	N	Feb97	Q	Psychotherapy	RR3	Apr97	15	1.11	1.11		Yes
90805	XXX	N	Feb97	Q	Psychotherapy	RR4	Apr97	15	1.47	1.47		Yes
90806	XXX	N	Feb97	Q	Psychotherapy	RR5	Apr97	15	1.73	1.72		Yes
90807	XXX	N	Feb97	Q	Psychotherapy	RR6	Apr97	15	2	2		Yes
90808	XXX	N	Feb97	Q	Psychotherapy	RR7	Apr97	15	2.76	2.76		Yes
90809	XXX	N	Feb97	Q	Psychotherapy	RR8	Apr97	15	3.15	3.15		Yes
90810	XXX	N	Feb97	Q	Psychotherapy	RR9	Apr97	15	1.19	1.19		Yes
90811	XXX	N	Feb97	Q	Psychotherapy	RR10	Apr97	15	1.58	1.58		Yes
90812	XXX	N	Feb97	Q	Psychotherapy	RR11	Apr97	15	1.86	1.86		Yes
90813	XXX	N	Feb97	Q	Psychotherapy	RR12	Apr97	15	2.15	2.15		Yes
90814	XXX	N	Feb97	Q	Psychotherapy	RR13	Apr97	15	2.97	2.97		Yes
90815	XXX	N	Feb97	Q	Psychotherapy	RR14	Apr97	15	3.39	3.39		Yes
90816	XXX	N	Feb97	Q	Psychotherapy	RR15	Apr97	15	1.24	1.24		Yes
90817	XXX	N	Feb97	Q	Psychotherapy	RR16	Apr97	15	1.65	1.65		Yes

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
90818	XXX	N	Feb97	Q	Psychotherapy	RR17	Apr97	15	1.94	1.94		Yes
90819	XXX	N	Feb97	Q	Psychotherapy	RR18	Apr97	15	2.24	2.24		Yes
90820	XXX	D	Feb97	Q	Psychotherapy		Apr97					Yes
90821	XXX	N	Feb97	Q	Psychotherapy	RR19	Apr97	15	3.09	3.09		Yes
90822	XXX	N	Feb97	Q	Psychotherapy	RR20	Apr97	15	3.53	3.53		Yes
90823	XXX	N	Feb97	Q	Psychotherapy	RR21	Apr97	15	1.33	1.33		Yes
90824	XXX	N	Feb97	Q	Psychotherapy	RR22	Apr97	15	1.77	1.77		Yes
90825	XXX	D	Feb97	Q	Psychotherapy		Apr97					Yes
90826	XXX	N	Feb97	Q	Psychotherapy	RR23	Apr97	15	2.08	2.08		Yes
90827	XXX	N	Feb97	Q	Psychotherapy	RR24	Apr97	15	2.41	2.41		Yes
90828	XXX	N	Feb97	Q	Psychotherapy	RR25	Apr97	15	3.32	3.32		Yes
90829	XXX	N	Feb97	Q	Psychotherapy	RR26	Apr97	15	3.8	3.8		Yes
90835	XXX	D	May97		Psychotherapy	RR27	Apr97	15				Yes
90841	XXX	D	Feb97	Q	Psychotherapy	RR28	Apr97					Yes
90842	XXX	D	Feb97	Q	Psychotherapy	RR29	Apr97					Yes
90843	XXX	D	Feb97	Q	Psychotherapy	RR30	Apr97					Yes
90844	XXX	D	Feb97	Q	Psychotherapy	RR31	Apr97					Yes
90845	XXX	R	Feb97	Q	Psychotherapy	RR32	Apr97	15	1.79	1.79	Yes	Yes
90846	XXX	R	Feb97	Q	Psychotherapy	RR33	Apr97	15	1.83	1.83	Yes	Yes

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
90847	XXX	R	Feb97	Q	Psychotherapy	RR34	Apr97	15	2.21	2.21	Yes	Yes
90849	XXX	R	Feb97	Q	Psychotherapy	RR35	Apr97	15	0.59	0.59	Yes	Yes
90853	XXX	R	Feb97	Q	Psychotherapy	RR36	Apr97	15	0.59	0.59	Yes	Yes
90855	XXX	D	Feb97	Q	Psychotherapy	RR37	Apr97					Yes
90857	XXX	R	Feb97	Q	Psychotherapy	RR38	Apr97	15	0.63	0.63	Yes	Yes
90865	XXX	N	May97		Psychotherapy	RR39	Apr97	15	2.84	2.84	Yes	Yes
90880	XXX	R	Feb97	Q	Psychotherapy	RR42	Apr97	15	2.19	2.19	Yes	Yes
90885	XXX	N	May97		Psychotherapy	RR43	Apr97	15	0.97	0.97	Yes	Yes
90911	000	R	Feb97	Q	Biofeedback Training	AI1	Editorial		0.89	0.89	Yes	Yes
91010	000	R	Feb97	Q	Esophageal Motility Studies	MM1	Editorial		1.25	1.25	Yes	Yes
91020	000	R	Feb97	Q	Esophageal Motility Studies	MM2	Editorial		1.44	1.44	Yes	Yes
92978	ZZZ	R	Feb97		Intravascular Ultrasound		Editorial		1.8	1.8	Yes	Yes
92979	ZZZ	R	Feb97		Intravascular Ultrasound		Editorial		1.44	1.44	Yes	Yes
92992	090	R	Feb97	34	Atrial Septectomy or Septostomy	AU1	Editorial		0	0	Yes	Yes
92997	000	N	Feb97	5	Pulmonary Artery Angioplasty	XX1	Apr97	31	19.93	12		Yes
92998	ZZZ	N	Feb97	5	Pulmonary Artery Angioplasty	XX1	Apr97	31	11.25	6		Yes
93320	ZZZ	R	Nov96	K	Doppler Echo		Editorial		0.38	0.38	Yes	Yes
93325	ZZZ	R	Nov96	K	Doppler Echo		Editorial		0.07	0.07	Yes	Yes
93508	000	N	May96	G	Coronary Angiography	D1	Sep96	11	4.1	4.1		Yes

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
93530	000	N	Feb97	49	Pediatric Cardiac Catheterization	AJ1	Apr97	A	6	4.23		Yes
93531	000	N	Feb97	49	Pediatric Cardiac Catheterization	AJ2	Apr97	A	8.35	8.35		Yes
93532	000	N	Feb97	49	Pediatric Cardiac Catheterization	AJ3	Apr97	A	10	10		Yes
93533	000	N	Feb97	49	Pediatric Cardiac Catheterization	AJ4	Apr97	A	7.5	6.7		Yes
94010	XXX	R	Nov96	2	Spirometry		Editorial		0.17	0.17	Yes	Yes
94070	XXX	R	Aug96	Z	Pulmonary Procedures	X1	Editorial		0.6	0.6	Yes	Yes
95805	XXX	R	May96	M	Sleep Studies	E1	Feb97	31	1.88	1.88	Yes	Yes
95806	XXX	R	May96	M	Sleep Studies	E3	Feb97	31	1.85	1.85		Yes
95807	XXX	R	May96	M	Sleep Studies	E2	Feb97	31	1.66	1.66	Yes	Yes
95811	XXX	N	May96	L	Sleep Studies	E4	Feb97	31	3.8	3.8		Yes
95860	XXX	R	Feb97	37	Needle EMG	AV1	Editorial		0.96	0.96	Yes	Yes
95861	XXX	R	Feb97	37	Needle EMG	AV2	Editorial		1.54	1.54	Yes	Yes
95863	XXX	R	Feb97	37	Needle EMG	AV3	Editorial		1.87	1.87	Yes	Yes
95864	XXX	R	Feb97	37	Needle EMG	AV4	Editorial		1.99	1.99	Yes	Yes
95869	XXX	R	Feb97	37	Needle EMG	AV5	Editorial		0.37	0.37	Yes	Yes
95870	XXX	N	May97	IX	Needle EMG	AV6	Sep97					Yes
96902	XXX	N	Aug96	5	Trichogram	S1	Apr97	E	0.7	0.41		Yes
97780	XXX	N	Feb97	L	Acupuncture	PP1	Sep97					Yes
97781	XXX	N	May97	IX	Acupuncture	PP2	Sep97					Yes

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
99141	XXX	N	Feb97	E	Conscious Sedation	NN1	Apr97	16	2.45	0.8		Yes
99142	XXX	N	Feb97	E	Conscious Sedation	NN2	Apr97	16	1.85	0.6		Yes
99217	XXX	R	Feb97	K	Observation Same Day Discharge		Editorial		1.28	1.28	Yes	Yes
99234	XXX	N	Feb97	K	Observation Same Day Discharge	OO1	Apr97	17	2.1	2.56		Yes
99235	XXX	N	Feb97	K	Observation Same Day Discharge	OO2	Apr97	17	3.1	3.42		Yes
99236	XXX	N	Feb97	K	Observation Same Day Discharge	OO3	Apr97	17	4.34	4.27		Yes
99315	XXX	N	Feb97	42	Nursing Facility Discharge	AF1	Apr97	19	1.28	1.2		Yes
99316	XXX	N	Feb97	42	Nursing Facility Discharge	AF2	Apr97	19	1.8	1.6		Yes
99341	XXX	R	Feb97	45	Home Care Visits	AG1	Apr97	20	1	0.89		Yes
99342	XXX	R	Feb97	45	Home Care Visits	AG2	Apr97	20	1.6	1.33		Yes
99343	XXX	R	Feb97	45	Home Care Visits	AG3	Apr97	20	2.5	1.99		Yes
99344	XXX	N	Feb97	45	Home Care Visits	AG4	Apr97	20	3.1	2.66		Yes
99345	XXX	N	Feb97	45	Home Care Visits	AG5	Apr97	20	3.75	3.32		Yes
99347	XXX	R	Feb97	45	Home Care Visits	AG6	Apr97	20	0.8	0.66		Yes
99348	XXX	R	Feb97	45	Home Care Visits	AG7	Apr97	20	1.4	1.11		Yes
99349	XXX	R	Feb97	45	Home Care Visits	AG8	Apr97	20	2	1.77		Yes
99350	XXX	N	Feb97	45	Home Care Visits	AG9	Apr97	20	3.53	2.66		Yes
99351	XXX	D	May97		Home Care Visits		Apr97	20				Yes
99352	XXX	D	May97		Home Care Visits		Apr97	20				Yes

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	SS Rec	RUC Rec	Same RVU as 1997?	MFS?
99353	XXX	D	May97		Home Care Visits		Apr97	20				Yes
99360	XXX	R	Feb97	47	Attendance at Delivery	AH1	Apr97	21				Yes
99374	XXX	N	Feb97	41	Care Plan Oversight	AE1	Apr97	18	1.1	1.1		Yes
99375	XXX	R	Feb97	41	Care Plan Oversight	AE2	Apr97	18	1.65	1.73		Yes
99376	XXX	D	Feb97	41	Care Plan Oversight	AE3	Apr97	18				Yes
99377	XXX	N	Feb97	41	Care Plan Oversight	AE4	Apr97	18	1.03	1.1		Yes
99378	XXX	N	Feb97	41	Care Plan Oversight	AE5	Apr97	18	1.73	1.73		Yes
99379	XXX	N	Feb97	41	Care Plan Oversight	AE6	Apr97	18	1.25	1.1		Yes
99380	XXX	N	Feb97	41	Care Plan Oversight	AE7	Apr97	18	1.89	1.73		Yes
99436	XXX	N	Feb97	47	Attendance at Delivery	AH2	Apr97	21	2.05	1.5		Yes

CPT 1998 RUC HCPAC Review Board Recommendations

15-May-97

CPT Code	Global Period	Coding Action	CPT Date	CPT Tab	Issue	Tracking Number	HCPAC Date	Tab	SS Rec	HCPAC Rec	Same RVU as 1997?	MFS?
11050	000	D	Feb97	V	Paring, Cutting, and Trimming of Nails	SS1	Apr97 (HCPAC)	C				Yes
11051	000	D	Feb97	V	Paring, Cutting, and Trimming of Nails	SS2	Apr97 (HCPAC)	C				Yes
11052	000	D	Feb97	V	Paring, Cutting, and Trimming of Nails	SS3	Apr97 (HCPAC)	C				Yes
11055	000	N	Feb97	V	Paring, Cutting, and Trimming of Nails	SS4	Apr97 (HCPAC)	C	0.43	0.43		Yes
11056	000	N	Feb97	V	Paring, Cutting, and Trimming of Nails	SS5	Apr97 (HCPAC)	C	0.61	0.61		Yes
11057	000	N	Feb97	V	Paring, Cutting, and Trimming of Nails	SS6	Apr97 (HCPAC)	C	0.79	0.79		Yes
11719	000	N	Feb97	V	Paring, Cutting, and Trimming of Nails	SS7	Apr97 (HCPAC)	C	0.17	0.17		Yes
29893	090	N	Feb97	1	Endoscopic Plantar Fasciotomy	UU1	Apr97 (HCPAC)	D	5.1	4.92		Yes
90875	XXX	R	Feb97	Q	Psychotherapy	RR40	Feb97 (HCPAC)	2	1.5	1.2		Yes
90876	XXX	R	Feb97	Q	Psychotherapy	RR41	Feb97 (HCPAC)	2	2.2	1.9		Yes
97001	XXX	N	Feb97	39	Occupational and Physical Therapy Evaluation	AD1	Apr97 (HCPAC)	E	1.34	1.2		Yes
97002	XXX	N	Feb97	39	Occupational and Physical Therapy Evaluation	AD2	Apr97 (HCPAC)	E	0.67	0.6		Yes
97003	XXX	N	Feb97	39	Occupational and Physical Therapy Evaluation	AD3	Apr97 (HCPAC)	E	1.34	1.2		Yes
97004	XXX	N	Feb97	39	Occupational and Physical Therapy Evaluation	AD4	Apr97 (HCPAC)	E	0.85	0.6		Yes

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
SEPTEMBER 1996

Intestinal Sling Procedure - Tab 9

A new CPT code 44700 was established to report the exclusion of small bowel from pelvis by mesh or other prosthesis, or native tissue (eg, bladder or omentum). Previously, this service would have been reported using an unlisted procedure code. This service may be performed as the primary service after an abdominal exploration. However, surgeons more commonly perform this procedure at the time of other pelvic operations (eg, abdominoperineal resection for rectal cancer). The procedure, when performed alone, is more extensive and involves intensive radiotherapy. This procedure is more difficult than exploratory laparotomy. It may be used to determine if pelvic exenteration is necessary.

The RUC accepted a relative value recommendation of 13.00 which was based on a survey median from over 30 colon and rectal surgeons. Key reference services for this new service are codes 44120 *Enterectomy, resection of small intestine; single resection and anastomosis* (work RVU = 13.15) and 45130 *Excision of Rectal Prolapsed, with anastomosis; perineal approach* (work RVU = 13.03). Pelvic exclusion to treat the underlying malignant condition involves extensive preoperative and postoperative counseling.

The RUC reviewed the relative value recommendations for this new code in comparison to 49568 *Implantation of mesh or other prosthesis for incisional hernia repair (list separately in addition to code for the incisional hernia repair)* (work RVU = 4.89), which is an add-on code with a global period of ZZZ. When performed with other pelvic operations, 44700 would be reported with a -51 modifier and reduced by 50% or 6.50 work RVUs. The RUC agreed that the intra-service work is significantly greater for 44700 because it is a riskier procedure and also requires more time. The intra-service time for 44700 is 120 minutes versus 52 minutes for 49568.

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
•44700	C1	Exclusion of small bowel from pelvis by mesh or other prosthesis, or native tissue (eg, bladder or omentum)	090	13.00

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 4416X Tracking Number: C1 Global Period: 090 Recommended RVW: 13.00

CPT Descriptor: Exclusion of small bowel from pelvis by mesh or other prosthesis, or native tissue (e.g., bladder or omentum) (For therapeutic radiation clinical treatment, see Radiology Oncology section)

CLINICAL DESCRIPTION OF SERVICE: This service may be performed as the primary service after an abdominal exploration. However, surgeons more commonly perform this procedure at the time of other major pelvic operations, e.g., abdominoperineal resection for rectal cancer.

Vignette Used in Survey: 76 y/o female with recurrent rectal cancer after APR undergoes exploration for possible resection of the recurrence. The tumor proves unresectable. To provide for postoperative pelvic radiation, the small bowel is excluded from the pelvis with an omental flap. The omentum is mobilized from the right and transverse colon. It is brought down to the pelvis along the left lateral aspect of the abdomen with care to preserve its blood supply. It is secured to the pelvic inlet with care to avoid ureteral injury.

Description of Pre-Service Work: Perform and review a complete history, physical and preoperative lab, X-ray and ECG profile. Counsel the patient and family about the operation and intraoperative decisions. After induction of anesthesia, position the patient in lithotomy with padding and protection of the lower extremities. Place foley catheter. Surgical scrub, gown, prep and drape patient.

Description of Intra-Service Work: After abdominal exploration through a midline incision, the small intestine is removed from the pelvis with appropriate lysis of adhesions. The abdominal and pelvic exploration assesses the resectability of the pelvic tumor. This includes assessment of bladder involvement, internal iliac venous invasion, extension to the lateral pelvis and hepatic metastases. The radiation fields are marked with metal clips for radiographic identification. The omentum is dissected free from the right and transverse colon with attention to preserving its blood supply. The surgeon eviscerates the small intestine to allow placement of the omental flap along the left lateral abdominal wall. A drain is placed within the pelvis and the flap is secured to the retroperitoneum at the pelvic inlet. The small intestine returns to the abdomen, excluded from the pelvis. The surgeon closes the abdominal incision.

Description of Post-Service Work: The surgeon documents the operative procedure and develops the postoperative orders. Assess postop labs, X-rays and drainage on the day of surgery. Postop visit in recovery and counseling of the family members. Five days of hospitalization with twice daily visits evaluating, assessing and managing the postanesthetic cardiopulmonary and renal status, labs, drainage, X-rays, pain management and resolution of the postop ileus. Consultation and Coordination with Radiation Oncologist, Oncologist and Home Health for subsequent chemoradiation and care. Three outpatient visits for assessment of wound, evidence of infection, pain management and further coordination of home care for primary malignancy.

SURVEY DATA:

Specialty: American Society of Colon and Rectal Surgeons

Sample Size: 50 Response Rate (%): 64 Median RVW: 13.13

25th Percentile RVW: 12 75th Percentile RVW: 14.025 Low: 3 High: 20

Median Pre-Service Time: 90 Median Intra-Service Time: 120

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 120 Low: 1 High: 210

Median Post-Service Time:

	Total Time	Number of Visits
Day of Procedure:	<u>30</u>	
ICU:	<u>25</u>	<u>1</u>
Other Hospital:	<u>90</u>	<u>6</u>
Office:	<u>45</u>	<u>3</u>

CPT Code: 4416X**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	44120	Enterectomy, resection of small intestine; single resection and anastomosis	13.15
2)	45130	Excision of Rectal Prolapsed, with anastomosis; perineal approach	13.03
3)	49560	Repair Initial Incisional Hernia, Reducible	11.00
4)	46260	Hemorrhoidectomy, Internal and External, complex or extensive	6.70

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Pelvic exclusion involves extensive preoperative and postoperative counseling because of the underlying malignant condition. The mental effort and judgment are associated with managing patients with cancers. The technical skill is similar to the incisional hernia repair with mesh. It involves similar incisions and lysis of adhesions. Incisional hernia repairs that require mesh involve an additional code - 49568 (RVW=4.89). The total value for an incisional hernia repair with addition of mesh is $11+4.89=15.89$. The work for hemorrhoidectomy represents approximately half the mental effort, judgment and technical skill of the pelvic exclusion. In comparing this procedure to intestinal resection reference codes - although the technical skill of an anastomosis exceeds the skill for pelvic exclusion, the total elements of work appear comparable. The ASCRS committee feels that the survey data supports the previously stated comparisons.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? Unlisted Procedure, Modifier -22, Unreported

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 5,000

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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SEPTEMBER 1996

Coronary Angiography- Tab 11

A new code 93508 *Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization* was added to provide a way to report catheter placement for coronary angiography without left heart catheterization, which requires crossing the aortic valve into the left ventricle with a catheter.

The work of 93508 is less than 93510 *Left heart catheterization* (work RVU = 4.33) and, therefore, the survey median of 5.05 was not recommended. The work and risk associated with crossing the aortic valve into the left ventricle with a catheter was determined to be .23. Which is slightly more work than 93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report* (work RVU = .17) and less work than 93545 *Injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand)* (work RVU = .29). The RUC recommends that the work RVU for 935XX be equivalent to 93510 less the increment of work of crossing the aortic valve ($4.33 - .23 = 4.10$).

The RUC also reviewed this service with the other codes that will be reported at the same time. A physician will report 93508 (4.10) for the catheter placement; 93545 (0.29) for the injection procedure; and 93555 (0.81) for the imaging supervision, interpretation and report, which will result in a total work RVU of 5.20.

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVW Recommendation
•93508	D1	Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization (93508 is to be used only when left heart catheterization, 93510, 93511, 93524, 93526 is not performed) (93508 is to be used only once per procedure)	000	4.10

CPT Code: 935XX Tracking Number: D1 Global Period: 000 Recommended RVW: 4.10CPT Descriptor:

Catheter placement in coronary artery (s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization

935XX is to be used only when left heart catheterization, 93510, 93511, 93524, 93526 is not performed.

935XX is to be used only once per procedure

CLINICAL DESCRIPTION OF SERVICE:Vignette Used in Survey:

See below.

Description of Pre-Service Work:

Pre-procedure work includes patient examination, discussion of the procedure and obtaining informed consent. Additional pre-procedure functions include writing orders for adequate sedation and patient support, and a review of study arrangements and procedures with technical, nursing and other assisting personnel.

Description of Intra-Service Work:

The procedure involves percutaneous insertion of a thin-walled needle into a peripheral artery followed by placement of a flexible guide wire, removal of the needle, insertion of a sheath/dilator system over the guide wire, removal of the dilator and guide wire and subsequent insertion of an appropriate catheter through the sheath into the arterial system under fluoroscopic guidance. The catheter is advanced retrograde through the arterial system to the ascending aorta. Pressures are measured in the aortic root. The catheter is then manipulated using fluoroscopic guidance into the ostium of a coronary artery, arterial bypass conduit or venous coronary bypass graft. Pressures are checked to be sure there is no evidence of catheter malposition or ostial stenosis. Test contrast injections under fluoroscopy may be made to check catheter position. The patient's arterial pressure and electrocardiogram are constantly monitored throughout the procedure.

Description of Post-Service Work:

Following completion of the procedure, the catheter and sheath are removed and hemostasis achieved by appropriate means by the physician or technician under the physician's supervision. A report of the procedure is prepared.

SURVEY DATA:

Specialty: American College of Cardiology

Sample Size: 28 Response Rate (%): 46 Median RVW: 5.05

25th Percentile RVW: 4.33 75th Percentile RVW: 6.44 Low: 1 High: 8.5

Median Pre-Service Time: 45 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 43.75 Low: 15 High: 70

Median Post-Service Time:

Total Time Number of Visits

Day of Procedure: 32.5 N/A

ICU: 0 0

Other Hospital: 20 1

Office: 20 1

CPT Code: 935XX**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	93510	Left heart catheterization	4.33
2)	93526	Combined right heart catheterization and retrograde left heart catheterization	5.99
3)	93545	Injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand)	0.29
4)	32100	Thoracotomy, major; with exploration and biopsy	10.07

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

Compare the pre-, intra-, and post-service time and the intensity (manual effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The work of placing a catheter for angiographic evaluation of the coronary vessels without concomitant angiography of the left ventricle is slightly less than that required when entering the left ventricle with a catheter. A recent survey indicates that a majority of physicians bill for this service using code 93510 which has an assigned work RVU level of 4.33. However, this code does not apply because it is specifically for left heart catheterization, which requires crossing the aortic valve into the left ventricle with a catheter. If coronary arteriography is done without left heart catheterization, then code 93510 should not be used. Since all other portions of both procedures are similar in time and intensity when compared without entering the left ventricle with a catheter, the ACC recommend that the value for this service be set at 4.10 work RVUs.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

The ACC utilized a two prong approach in determining the appropriate RVU level for code 935XX. First, data was collected from a survey distributed to 61 cardiologists which suggested an RVU level of 5.05 when performing catheter placement for coronary angiography. Secondly, the ACC created a consultation advisory group to review the information collected from the survey. After considerable discussion, the panel determined to maintain relativity within the current CPT coding scale and recommend 4.10.

FREQUENCY INFORMATION

How was this service previously reported? See above referenced service codes

How often do physicians in your specialty perform this service? X Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 30,000

Is this service performed by many physicians across the United States? X Yes No

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Intraoperative Endovascular Angioscopy - Tab 15

CPT code 35400 *Angioscopy (non-coronary vessels or grafts) during therapeutic intervention (list separately in addition to code for primary procedure)* was created to describe a modality which allows direct "real-time" visualization of critical portions of a bypass procedure such as mechanical disruption of the fine valves within a vein, minimizing the risk of vein injury. The use of the angioscope also reduces the risk of postoperative skin edge necrosis and wound infection in chronically ischemic limbs.

The RUC recommends a work RVU of 3.0, which is based on the survey responses of nearly 50 vascular surgeons. The time and intensity of 35400 is comparable with both codes 35700 *Reoperation, femoral-popliteal or femoral (popliteal) - anterior tibial, posterior tibial, peroneal artery or other distal vessels, more than one month after original operation (List separately in addition to code for primary procedure)* (3.08) and 35390 *Reoperation, carotid, throboendarterectomy, more than one month after original operation (List separately in addition to code for primary procedure)* (3.19).

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	RVU Recommendation
•35400	I1	Angioscopy (non-coronary vessels or grafts) during therapeutic intervention (list separately in addition to code for primary procedure)	ZZZ	3.00

CPT Code: 372XX Tracking Number: II Global Period: ZZZ Recommended RVW: 3.00

CPT Descriptor: Angioscopy (non-coronary vessels or grafts) during therapeutic intervention (list separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

68 year old male presented with non-healing gangrene of the base of toes three and four of the right foot. This patient was admitted for planned lower extremity revascularization for limb salvage. Due to the advanced peripheral vascular disease and the potential for poor wound healing the goal is to use minimal incision sites in performing this operation. A right femoral-dorsalis pedis in situ saphenous vein bypass was performed using angioscopy for venous valve lysis, identification of side branch ligation and visualization of distal anastomosis and distal dorsalis pedis artery.

NOTE: This clinical vignette was used for the CPT application in order to clearly identify the setting in which the angioscope is used. The vignette describes both the work of the bypass operation and the work of angioscopy. All the pre- and post-service work, and all the intra-service surgical bypass work is already included in the RVW of the bypass itself. To determine the work of angioscopy alone, survey respondents were clearly instructed to consider only the extra intra-service time and intensity required to perform the angioscopy.

Description of Pre-Service work:

Pre-service work consists of a pre-operative angiogram of the right lower extremity, superficial femoral artery, popliteal artery and trifurcation arteries to the foot. Angiography findings revealed severe stenosis of the popliteal artery with severe calcification of the trifurcation vessels. Based on these findings, plans were made to bypass to the right dorsalis pedis artery.

Description of Intra-Service work:

An incision was made proximally to isolate the superficial saphenous vein and ligate the vein from the sapheno-femoral junction. Dissection was completed to isolate the superficial femoral artery, common femoral and profunda femoris arteries. A distal incision was made to isolate the dorsalis pedis artery as well as the superficial saphenous vein. After set-up and appropriate focusing a 1.9mm diameter angioscope was inserted proximally. A 120cm length valvulotome was inserted distally and advanced to the proximal vein segment. The proximal valves were disrupted under the direct vision of the angioscope. At the same time, the venous tributaries were identified via angioscopy. Small skin incisions were made to ligate the tributaries that were identified with the use of angioscopy. Valve lysis and ligation of tributaries was completed the entire length of the saphenous vein using this method. The angioscope was slowly removed from the saphenous vein visualizing complete valve lysis and ligation of tributaries. An end-to-side anastomosis was made to the dorsalis pedis artery. Following completion of the anastomosis, the angioscopy was introduced into the proximal saphenous vein and advanced to the distal anastomosis and into the dorsalis pedis artery. The anastomosis was well visualized showing no technical deficits. The proximal dorsalis pedis artery was small and with some disease but no significant obstructive disease. The angioscope was slowly removed from the vein

revealing lysed valves and no inflow from tributaries. The proximal anastomosis was completed and the incisions closed in the usual manner. Minimal incisions were accomplished for this procedure. An approximate three inch incision was made proximally and distally with six one inch incisions made the length of the extremity to ligate the venous tributaries.

Description of Post-Service work:

The patient was transferred to the recover room in stable condition. A strong pulse was identified in the newly formed bypass as well as distal foot arteries.

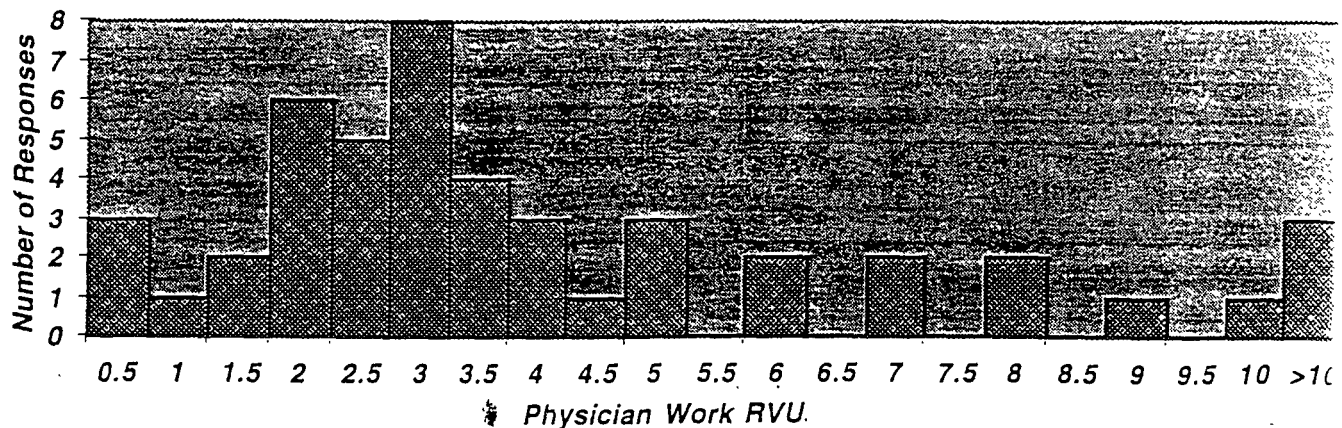
SURVEY DATA:

Specialty: Society for Vascular Surgery (SVS)
and North American Chapter International Society for Cardiovascular Surgery (ISCVS-NA)

Survey n: 150 Response: 46 Rate %: 31% Experience: 15 (median)

	RVW	PRE total min	INTRA total min	POST total min	IWPUT (recomnd RVW/ intra min)
low	0.50		1		
25th%	2.30		30		
MED	3.00		45		0.067
75th%	5.00		56		
high	35.00		210		

Histogram of Survey Work RVU Responses



KEY REFERENCE SERVICE(S):

Resp (n)	CPT Code	CPT Descriptor	96rvw	97rvw	global period
15	36625	arterial catheterization by cutdown for sampling/monitoring	2.11	no chg	000
15	35700	reoperation, femoral-popliteal or femoral-tib (list separately)	3.08	no chg	ZZZ
12	34201	embolectomy or thrombectomy, w/w/o catheter, leg incision	8.04	no chg	090
9	35390	reoperation, carotid thromboendarterectomy (list separately)	3.19	no chg	ZZZ
7	37720	ligation and division and complete stripping saphenous veins	5.22	no chg	090
6	93880	duplex scan of extracranial arteries: complete bilateral (professional)	0.60	no chg	XXX

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

CPT Code	96/97 RVW & global	Pre-svc min median	Intra-svc min median	Post-svc min median	Ment Eff & Judge median	Tech Skl Phys Eff median	Psych Stress median	Experience med/yr
I1	?? ZZZ	N/A	45	N/A	4	4	3	15
36625	2.11 000	10	20	5	2	3	2	6
35700	3.08 ZZZ	N/A	48	N/A	4	4	3	10
34201	8.04 090	30	45	60	4	4	3	15
35390	3.19 ZZZ	N/A	40	N/A	4	4	4	4
37720	5.22 090	30	60	30	2	2	2	10
93880	0.60 XXX	5	25	12	3	2	2	10

ADDITIONAL RATIONALE

Intraoperative determination of the technical adequacy of a vascular reconstructive procedure is considered an important aspect of quality care. In the earlier days of vascular surgery, intraoperative angiography was really the only option for such an evaluation, and when a vascular surgeon performed a lower extremity bypass graft, an "on-the-table" angiogram (e.g. CPT 75710) performed prior to skin closure was considered the standard of care. In the late 1980's and 1990's two new technologies were introduced as options to the intraoperative angiogram. These were intraoperative angioscopy (the code being evaluated currently) and duplex ultrasound (e.g. CPT 76986 or 93926).

For many surgeons, angioscopy gained favor over the other modalities for at least two reasons. First, it allows direct "real-time" visualization of critical portions of a bypass procedure such as during mechanical disruption of the fine valves within a vein, thereby minimizing the likelihood of vein injury. Second, use of the angioscope provides the potential to reduce the length of the operative skin incision, reducing the risk of postoperative skin edge necrosis and wound infection in these chronically ischemic limbs. The downside of angioscope use is that it prolongs the operative procedure. Although a few minutes may be saved in not performing (and subsequently closing) a skin incision, introduction of the scope and manipulation of the instruments from the ends of the vein typically prolong the overall time spent during a peripheral bypass operation. With

increasing aggressiveness towards angioscopically-assisted valve lysis and skin incision length reduction, the time and complexity of a bypass procedure increase substantially. Nevertheless, surgeons who employ the angioscope routinely believe that a higher quality revascularization is accomplished with a reduced likelihood for wound complications.

The other modalities for intraoperative technical assessment, angiography and duplex ultrasound, allow a "one-shot" evaluation of a graft once it's completed, but they don't offer realtime visualization of crucial aspects of the operation, nor do they offer potential to reduce the length of the surgical skin incision. Thus, angiography has become more integrated in actual performance of the operation than the alternative modalities, and as such, a substantially greater RVW is justified in comparison to those pre-existing methods of intraoperative assessment (e.g. the 1997 RVW for CPT 75710, angiography of a unilateral extremity, radiological supervision and interpretation, is 1.14 RVUs).

FREQUENCY INFORMATION

1. How was this service previously reported?

Until now, there have been no accurate codes to describe intraoperative angiography. Some physicians have used 37799, unlisted procedure in vascular surgery, or added exceptional service modifiers such as -22 to bill for this service.

2. How often do physicians in your specialty perform this service?

"Commonly" is probably the best one word answer for surgeons who use the technology, although infrainguinal vascular reconstructions using venous conduit are certainly not commonplace, and the median experience in our survey was 15 angioscope procedures per year.

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

Once again, this is a difficult question to answer for a service which until now has had no CPT code, nor any other reasonable means of frequency tracking on a national basis. Our CPT application sent early in 1996 cited use of angiography during peripheral vascular interventions including infrainguinal revascularizations, carotid endarterectomies, and hemodialysis access surgery. These indications were included since multiple publications exist identifying the utility of the angioscope in each situation. Nevertheless, the actual clinical usage and the frequency distribution among these various applications were not clear. We attempted to accumulate data in this regard with the survey instrument. An additional question was added to the survey asking all respondents to indicate the percentage of total angioscope use devoted to various applications. The median responses were as follows:

Angioscopically assisted lower extremity bypass graft operation (as in vignette):	85%
Evaluation of technical adequacy of carotid endarterectomy:	0%
Evaluation of technical adequacy of dialysis graft thrombectomy:	0%
Evaluation of technical adequacy of arterial or bypass graft thrombectomy:	10%
Other:	0%

Thus, according to the only data available to us, the clinical vignette is accurate in terms of the type of case in which the angioscope is used, and alternative uses are not common. In order to

estimate the number of usages per year we also need the percentage of surgeons who use the angioscope. Once again, we are unaware of such data, but a generous estimate would be 50% of those people performing infrainguinal revascularizations. Since this instrument is very unlikely to be used when a bypass graft is performed using synthetic conduit rather than autogenous vein, all synthetic reconstructions may be excluded. The overall usage, therefore, would be the sum of all lower extremity bypass grafts using venous conduit (6 CPT codes) x (50% usage):

CPT code	Descriptor	1993 Medicare frequency
35556	femoral-popliteal bypass using vein	9,999
35566	femoral-tibial bypass using vein	7,446
35571	popliteal-tibial bypass using vein	3,658
35583	femoral-popliteal bypass using in-situ vein	4,507
35585	femoral-tibial bypass using in-situ vein	7,646
35587	popliteal-tibial bypass using in-situ vein	1,045
Total:		34,301

Final Estimate of annual (Medicare) angioscope usage for infrainguinal revascularization =

$$34,301 \times 50\% = 17,151$$

Estimate for other surgical indications: <1,000 per year for each of the following other procedures: carotid endarterectomy, dialysis graft thrombectomy, arterial or bypass graft thrombectomy, other.

4. Does the typical patient/service listed on Page 1 of the survey describe your typical patient?

Of the 46 survey respondents, 38 (83%) answered this question "yes". The remaining 8 respondents (17%) identified the patient as being typical, but their use of the angioscope differed from that described in the vignette. Of these 8, most said they use the angioscope to lyse the vein valves under direct vision, and they use it to check the technical adequacy of the reconstruction, but they don't use it to identify the vein branches which would allow them to limit the length of the surgical incision. Thus, a small number of users would perform slightly less work than described in the vignette. The other sub-group noted that they use the angioscope to deliver vein branch occluding stents, an on-protocol procedure which would entail more angioscope work than described in the vignette. Overall, these data lead us to believe the vignette appropriately represents the typical patient, the most common indication for angioscope use, and an appropriate level of use of the angioscope.

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Percutaneous Abscess Drainage - Tab 16

A survey was conducted of interventional radiologists to determine the work of several new percutaneous abscess drainage codes. The survey respondents were asked to consider a global period of 90 days for these services. The RUC chose not to use this survey data in developing its recommendations because the global period of 90 days is not appropriate for these services. The RUC recommends that all percutaneous drainage codes be assigned a global period of 0 days. Patients receiving these services do not typically receive their follow-up care by the interventional radiologist who performs the procedure and, therefore, a global period of 90 days is not appropriate.

The RUC recommends work RVUs for these services based on comparison to established CPT codes with global periods of 0 days. The codes were grouped by level of difficulty and are valued as follows:

Similar in work to CPT code 32020 *Tube thoracostomy with or without water seal (EG, for abscess, hemothorax, empyema) (separate procedure) (work rvu = 3.98)*. Therefore the RUC recommends a value of 4.00 RVUs for the following codes:

<u>Code</u>	<u>Tracking #</u>	<u>Description</u>
32201	K2	Pneumonostomy; with percutaneous drainage of abscess or cyst
48511	K8	External drainage, pseudocyst of pancreas; percutaneous
49041	K10	Drainage of subdiaphragmatic or subphrenic abscess; percutaneous

The RUC recommends that the following codes be valued at a mid-point between CPT codes 32020 and 50392. The RUC recommends that these codes be valued at 3.70 RVUs:

47011	K6	Hepatotomy; for percutaneous drainage of abscess or cyst, one or two stages
49061	K12	Drainage of retroperitoneal abscess; percutaneous

The RUC believes that the following codes are similar in work to 50392 *Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous* (work rvu = 3.38). Therefore the RUC recommends that these codes be valued at 3.38 RVUs.

44901	K4	Incision and drainage of appendiceal abscess; percutaneous
49021		Drainage of peritoneal abscess or localized peritonitis, exclusive or appendiceal abscess; percutaneous
50021	K14	Drainage of perirenal or renal abscess; percutaneous
58823	K17	Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg ovarian, pericolic)

The RUC also recommends a work rvu for 49424 (K18) equivalent to code 50394 *Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter* (work rvu = .76).

A work rvu of 1.46 is recommended for 49423 (K19), which is equivalent to code 50398 *Change of nephrostomy or pyelostomy tube*.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
32200	K1	Pneumonostomy; with open drainage of abscess or cyst	090	13.10(no change)
•32201	K2	with percutaneous drainage of abscess or cyst (For radiological supervision and interpretation, see 75989)	000	4.00
44900	K3	Incision and drainage of appendiceal abscess; transabdominal; open	090	7.86(no change)
•44901	K4	percutaneous (For radiological supervision and Interpretation, see 75989)	000	3.38
47010	K5	Hepatotomy; for <u>open</u> drainage of abscess or cyst, one or two stages	090	8.75(No Change)
•47011	K6	for percutaneous drainage of abscess or cyst, one or	000	3.70

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

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		two stages (For radiological supervision and interpretation, see 75989)		
48510	K7	External drainage, pseudocyst of pancreas; <u>open</u>	090	11.22(no change)
•48511	K8	percutaneous (For radiological supervision and interpretation, see 75989)	000	4.00
49020		Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; <u>open</u> (For appendiceal abscess, see 44900)		14.25(no change)
49021	new code in 1997	percutaneous		3.38
49040	K9	Drainage of subdiaphragmatic or subphrenic abscess; <u>open</u>	090	8.74(no change)
•49041	K10	percutaneous (For radiological supervision and interpretation, see 75989)	000	4.00
49060	K11	Drainage of retroperitoneal abscess; <u>open</u>	090	10.55(no change)
•49061	K12	percutaneous (For radiological supervision and interpretation, see 75989)	000	3.70
50020	K13	Drainage of perirenal or renal abscess (separate procedure); <u>open</u>	090	12.41(no change)
•50021	K14	percutaneous (For radiological supervision and interpretation, see 75989)	000	3.38
58820	K15	Drainage of ovarian abscess; vaginal approach; <u>open</u>	090	3.96(no change)
58822	K16	abdominal; <u>open</u>	000	9.06(no change)

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

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•58823	K17	Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic) (For radiological supervision and interpretation, see 75989)	000	3.38
•49424	K18	Contrast injection for assessment of abscess or cyst via previously placed catheter (separate procedure) (For radiological supervision and interpretation, see 76080)	000	0.76
•49423	K19	Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure) (For radiological supervision and interpretation, see 75984)	000	1.46
75989	K20	Radiological guidance for percutaneous drainage of abscess, or specimen collection (ie, fluoroscopy, ultrasound, or computed tomography), with or without placement of indwelling catheter, radiological supervision and interpretation	XXX	1.19(no change)
76080	K21	Radiologic examination, <u>abscess</u> , fistula or sinus tract study, radiological supervision and interpretation	XXX	0.54(no change)

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

Society of Cardiovascular & Interventional Radiology
American College of Radiology

CPT Code: 3220X Tracking Number: (K2) Global Period: 090 **Recommended RVW: 8.70**

CPT Descriptor: Pneumonostomy, with percutaneous drainage of abscess or cyst (For radiological supervision and interpretation, see 75989)

CLINICAL DESCRIPTION OF SERVICE

Vignette Used in Survey:

A thirty-three year old with a history of AIDS and alcoholism presents obtunded with fever, sepsis, hypotension, and hypoxia requiring intubation and pressor support. Chest radiograph reveals a cavitating lesion in the left lower lobe. A sputum culture grows staph Aureus. A drainage catheter is placed under CT guidance. Catheter output is monitored daily. Resolution of the abscess is measured by clinical condition, imaging studies, and laboratory tests. The patient is followed as an outpatient and after complete resolution the catheter is removed.

Description of Pre-Service Work:

(See attachment)

Description of Intra-Service Work:

(See attachment)

Description of Post-Service Work:

(See attachment)

SURVEY DATASpecialty: Society of Cardiovascular & Interventional RadiologySample Size: 76 Response Rate: 47% (n=36) Median RVW: 8.7525th Percentile RVW: 6.24 75th Percentile RVW: 10.63 Low: 4.60 High: 14.00Median Pre-Service Time: 45 Median Intra-Service Time: 6025th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 75 Low: 30 High: 120Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 28ICU: 30 2.25Other Hospital: 60 4Office: 20 2

Specialty: American College of RadiologySample Size: 110 Response Rate: 25% (n=28) Median RVW: 8.6325th Percentile RVW: 6.16 75th Percentile RVW: 11.10 Low: 3.98 High: 13.10Median Pre-Service Time: 30 Median Intra-Service Time: 6025th Percentile Intra-Svc Time: 42.5 75th Percentile Intra-Svc Time: 60 Low: 30 High: 90Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 20ICU: 30 2Other Hospital: 40 4Office: 25 2

KEY REFERENCE SERVICES

	CPT Code	CPT Descriptor	RVW		Societies
			1996	1997	
1)	47510	Introduction of percutaneous transhepatic catheter for biliary drainage	7.39	7.39	SCVIR/ACR
2)	47511	Introduction of percutaneous transhepatic stent for internal and external biliary drainage	9.91	9.91	SCVIR

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICES

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time		Median Intra-Time		Median Post-Time		Median Mental Effort & Judgement		Median Technical Skill & Physical Effort		Median Psychological Stress	
	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR
3220X	45	30	60	60	28	20	4	4	4	4	4	4
47510	50	37.5	90	82.5	30	30	4	4	4	4	4	3.5
47511	60	n/a	100	n/a	25	n/a	4	n/a	4	n/a	4	n/a

	SCVIR	ACR
Number of times performed in last 12 months (median)	5	5
Agree with vignette?	89%	89%

ADDITIONAL RATIONALE

The recommended RVW is based on the survey median RVWs from the SCVIR and the ACR, weighted by the number of survey respondents to the respective surveys.

FREQUENCY INFORMATION

How was this service previously reported? 32200

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

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

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

Clinical Description of Service and Vignette

Code 3220X: Pneumonostomy, with percutaneous drainage of abscess or cyst

Clinical Vignette: A thirty-three year old with a history of AIDS and alcoholism presents obtunded with fever, sepsis, hypotension, and hypoxia requiring intubation and pressor support. Chest radiograph reveals a cavitating lesion in the left lower lobe. A sputum culture grows staph Aureus. A drainage catheter is placed under CT guidance. Catheter output is monitored daily. Resolution of the abscess is measured by clinical condition, imaging studies, and laboratory tests. The patient is followed as an outpatient and after complete resolution the catheter is removed.

Description of Physician Work Associated With This Procedure:

	Include These Services In Your Work RVU Estimate (Only If <u>You</u> Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Pre-Service Work	<ul style="list-style-type: none">• Review previous diagnostic studies, clinical findings, and laboratory data.• Examine patient• Explain risks, benefits, and alternatives to patient.• Obtain informed consent.• Discuss procedure with patient's family and other physicians.	

(Continued on next page)

Code 3220X

Description of Physician Work Associated With This Procedure (Cont.):

	Include These Services In Your Work RVU Estimate (Only If <u>You</u> Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Intra-Service Work	<ul style="list-style-type: none"> • Direct the placement of hemodynamic ECG and pulse oximetry monitors. • Order I.V. antibiotics and conscious sedation. • Prep and drape patient. • Select and anesthetize approach site(s). • Position needle(s) and insert into collection(s). • Aspirate fluid (e.g. pus) and send for evaluation. • Pass guidewire(s) into collection(s). • Dilate tract over guidewire(s) and place appropriate size and configuration drainage catheter(s). • Aspirate and irrigate abscess(es). • Secure catheter(s) and place to gravity drainage. 	<ul style="list-style-type: none"> • Chest CT to determine best approach to abscess, drainage needle insertion, and for confirmation of positioning (code 75989; RVW=1.19).
Routine Post-Service Work	<ul style="list-style-type: none"> • Write operative notes/orders. • Discuss results with patient, his/her family, and other physicians. • Daily ward rounds to assess patient, check catheter(s), irrigate tube(s), change dressings, etc. • Discharge of patient from hospital. • Post-hospital office visits. (Please report frequency and level of office visits on questionnaire.) • Remove catheter(s). 	<ul style="list-style-type: none"> • Contrast injection with imaging [codes 49XX1 (RVW=TBD) and 76080 (RVW=0.54)], <i>if performed.</i> • Exchange drainage catheter with imaging guidance [codes 49XX2 (RVW=TBD) and 75984 (RVW=0.72)], <i>if performed.</i> • Post drainage imaging (e.g. CT, ultrasound), <i>if performed.</i>

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION
American College of Radiology
Society of Cardiovascular and Interventional Radiology

CPT Code: 4490X Tracking Number: K4 Global Period: 090 Recommended RVW: ~~7.72~~ ^{3.38 RUC REC}

CPT Descriptor: Incision and drainage of appendiceal abscess; percutaneous (for radiological supervision and interpretation, see 75989)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 28-year old man with a four day history of right lower quadrant pain, fever, and peritoneal signs is admitted to the hospital. Physical examination reveals a fluctuant mass in the right lower quadrant and signs of peritonitis. The patient has been febrile to 103 degrees F. and laboratory evaluation reveals a white blood cell count of $19,000/\text{mm}^3$. Abdominal abscess is suspected and a CT study reveals an indurated cecum and appendiceal region without visualization of the appendix. An appendicolith is demonstrated adjacent to a 4 centimeter fluid collection with an enhancing wall. Catheter drainage of the abscess is performed. Catheter output is monitored daily. Resolution of the abscess is measured by clinical condition of the patient as well as laboratory and imaging studies. The patient is followed as an outpatient and the catheter is removed after clinical resolution.

Description of Pre-Service Work:

See Attachment

Description of Intra-Service Work:

See Attachment

Description of Post-Service Work:

See Attachment

SURVEY DATA:

Specialty: American College of RadiologySample Size: 110 Response Rate (%): N = 28 (25%) Median RVW: 8.025th Percentile RVW: 6.03 75th Percentile RVW: 10.0 Lowest RVW: 4.0 Highest RVW: 12.8Median Pre-Service Time: 30 minutes Median Intra-Service Time: 60 minutes25th Percentile Intra-Service Time: 45 minutes75th Percentile Intra-Service Time: 70 minutesLowest Intra-Service Time: 30 minutesHighest Intra-Service Time: 90 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>20</u>	
ICU:	<u>20</u>	<u>2</u>
Other Hospital:	<u>45</u>	<u>4</u>
Office:	<u>20</u>	<u>15</u>

Specialty: Society of Cardiovascular and Interventional RadiologySample Size: 76 Response Rate (%): 49% (N = 37) Median RVW: 7.525th Percentile RVW: 6.8 75th Percentile RVW: 8.75 Lowest RVW: 4 Highest RVW: 12Median Pre-Service Time: 45 minutes Median Intra-Service Time: 60 minutes25th Percentile Intra-Service Time: 45 minutes75th Percentile Intra-Service Time: 70 minutesLowest Intra-Service Time: 30 minutesHighest Intra-Service Time: 100 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>20</u>	
ICU:	<u>1</u>	<u>0</u>
Other Hospital:	<u>50</u>	<u>4</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>1996 (1997) RVW</u>	<u>Societies</u>
1)	47510	Introduction of percutaneous transhepatic catheter for biliary drainage	7.39 (7.39)	ACR/SCVIR
2)	43750	Percutaneous placement of gastrostomy tube	5.71 (4.27)	SCVIR

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

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time		Median Intra-Time		Median Post-Time		Median Mental Effort & Judgment		Median Technical Skill & Physical Effort		Median Psychological Stress	
	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR
4490X	30	45	60	60	20	20	4	3	4	3	3	3
47510	45	50	90	90	37.5	30	4	4	4	4	4	4
43750	NA	30	NA	45	NA	20	NA	3	NA	3	NA	3

	ACR	SCVIR
Number of times performed in last 12 months (median)	5	6
Agree with vignette?	Yes (100%, N=28)	Yes (89%, N=33) No (11%, N=4)

ADDITIONAL RATIONALE

The recommended RVW is based on the survey median RVWs from the ACR and the SCVIR, weighted by the number of survey respondents to the respective surveys.

FREQUENCY INFORMATION

How was this service previously reported? _____

How often do physicians in your specialty perform this service?

Commonly X Sometimes Rarely

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

Is this service performed by many physicians across the United States? Yes X No

Clinical Description of Service and Vignette

Code 4490X: Incision and drainage of appendiceal abscess; percutaneous

Clinical Vignette: A 28-year old man with a four day history of right lower quadrant pain, fever, and peritoneal signs is admitted to the hospital. Physical examination reveals a fluctuant mass in the right lower quadrant and signs of peritonitis. The patient has been febrile to 103 degrees F. and laboratory evaluation reveals a white blood cell count of 19,000/mm³. Abdominal abscess is suspected and a CT study reveals an indurated cecum and appendiceal region without visualization of the appendix. An appendicolith is demonstrated adjacent to a 4 centimeter fluid collection with an enhancing wall. Catheter drainage of the abscess is performed. Catheter output is monitored daily. Resolution of the abscess is measured by clinical condition of the patient as well as laboratory and imaging studies. The patient is followed as an outpatient and the catheter is removed after clinical resolution.

Description of Physician Work Associated With This Procedure:

	Include These Services In Your Work RVU Estimate (Only If <u>You</u> Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Pre-Service Work	<ul style="list-style-type: none">• Review previous diagnostic studies, clinical findings, and laboratory data.• Examine patient• Explain risks, benefits, and alternatives to patient.• Obtain informed consent.• Discuss procedure with patient's family and other physicians.	

Code 4490X

Description of Physician Work Associated With This Procedure (Cont.):

	Include These Services In Your Work RVU Estimate (Only If <u>You</u> Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Intra-Service Work	<ul style="list-style-type: none"> • Direct the placement of hemodynamic ECG and pulse oximetry monitors. • Order I.V. antibiotics and conscious sedation. • Prep and drape patient. • Select and anesthetize approach site(s). • Position needle(s) and insert into collection(s). • Aspirate fluid (e.g. pus) and send for evaluation. • Pass guidewire(s) into collection(s). • Dilate tract over guidewire(s) and place appropriate size and configuration drainage catheter(s). • Aspirate and irrigate abscess(es). • Secure catheter(s) and place to gravity drainage. 	<ul style="list-style-type: none"> • Abdominal CT to determine best approach to abscess, drainage needle insertion, and for confirmation of positioning (code 75989; RVW=1.19)
Routine Post-Service Work	<ul style="list-style-type: none"> • Write operative notes/orders. • Discuss results with patient, his/her family, and other physicians. • Daily ward rounds to assess patient, check catheter(s), irrigate tube(s), change dressings, etc. • Discharge of patient from hospital. • Post-hospital office visits. (Please report frequency and level of office visits on questionnaire.) • Remove catheter(s). 	<ul style="list-style-type: none"> • Contrast injection with imaging [codes 49XX1 (RVW=TBD) and 76080 (RVW=0.54)], <i>if performed.</i> • Exchange drainage catheter with imaging guidance [codes 49XX2 (RVW=TBD) and 75984 (RVW=0.72)], <i>if performed.</i> • Post drainage imaging (e.g. CT, ultrasound), <i>if performed.</i>

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

Society of Cardiovascular & Interventional Radiology
American College of Radiology

CPT Code: 470XX Tracking Number: (K6) Global Period: 090 **Recommended RVW: 8.50**

CPT Descriptor: Hepatotomy; for percutaneous drainage of abscess or cyst, one or two stages. (For radiological supervision and interpretation, see 75989)

CLINICAL DESCRIPTION OF SERVICE

Vignette Used in Survey:

A fifty-six year old woman with recent diverticulitis presents with right upper quadrant pain of two week's duration, fever, and rigors. CT and ultrasound examinations reveal a complex multiloculated fluid collection in the liver. Catheter drainage of the abscess is performed. Catheter output is monitored daily. Resolution of the abscess is measured by clinical condition, imaging studies, and laboratory tests. The patient is followed as an outpatient and after complete resolution the catheter is removed.

Description of Pre-Service Work:

(See attachment)

Description of Intra-Service Work:

(See attachment)

Description of Post-Service Work:

(See attachment)

SURVEY DATASpecialty: Society of Cardiovascular & Interventional RadiologySample Size: 76 Response Rate: 49% (n=37) Median RVW: 8.5025th Percentile RVW: 7.35 75th Percentile RVW: 9.75 Low: 5.00 High: 12.55Median Pre-Service Time: 45 Median Intra-Service Time: 6025th Percentile Intra-Svc Time: 50 75th Percentile Intra-Svc Time: 75 Low: 20 High: 120Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
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Day of Procedure:	<u>30</u>	
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ICU:	<u>30</u>	<u>2</u>
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Other Hospital:	<u>60</u>	<u>4</u>
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Office:	<u>40</u>	<u>2</u>
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Specialty: American College of RadiologySample Size: 110 Response Rate: 25% (n=28) Median RVW: 8.5025th Percentile RVW: 6.28 75th Percentile RVW: 10.00 Low: 10.00 High: 13.00Median Pre-Service Time: 30 Median Intra-Service Time: 6025th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 70 Low: 35 High: 90Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
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Day of Procedure:	<u>20</u>	
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ICU:	<u>20</u>	<u>3</u>
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Other Hospital:	<u>55</u>	<u>5</u>
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Office:	<u>25</u>	<u>1.5</u>
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KEY REFERENCE SERVICES

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>		<u>Societies</u>
			<u>1996</u>	<u>1997</u>	
1)	47510	Introduction of percutaneous transhepatic catheter for biliary drainage	7.39	7.39	SCVIR/ACR
2)	47511	Introduction of percutaneous transhepatic stent for internal and external biliary drainage	9.91	9.91	SCVIR

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICES

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time		Median Intra-Time		Median Post-Time		Median Mental Effort & Judgement		Median Technical Skill & Physical Effort		Median Psychological Stress	
	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR
470XX	45	30	60	60	30	20	4	4	4	4	4	4
47510	50	45	90	90	30	30	4	4	4	4	4	4
47511	60	n/a	100	n/a	25	n/a	4	n/a	4	n/a	4	n/a

	SCVIR	ACR
Number of times performed in last 12 months (median)	6	5
Agree with vignette?	97%	96%

ADDITIONAL RATIONALE

The recommended RVW is based on the survey median RVWs from the SCVIR and the ACR, weighted by the number of survey respondents to the respective surveys.

FREQUENCY INFORMATION

How was this service previously reported? 47010

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

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

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

Clinical Description of Service and Vignette

Code 470XX: Hepatotomy; for percutaneous drainage of abscess or cyst, one or two stages

Clinical Vignette: A fifty-six year old woman with recent diverticulitis presents with right upper quadrant pain of two week's duration, fever, and rigors. CT and ultrasound examinations reveal a complex multiloculated fluid collection in the liver. Catheter drainage of the abscess is performed. Catheter output is monitored daily. Resolution of the abscess is measured by clinical condition, imaging studies, and laboratory tests. The patient is followed as an outpatient and after complete resolution the catheter is removed.

Description of Physician Work Associated With This Procedure:

	Include These Services In Your Work RVU Estimate (Only If <u>You</u> Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Pre-Service Work	<ul style="list-style-type: none">• Review previous diagnostic studies, clinical findings, and laboratory data.• Examine patient• Explain risks, benefits, and alternatives to patient.• Obtain informed consent.• Discuss procedure with patient's family and other physicians.	

(Continued on next page)

Code 470XX

Description of Physician Work Associated With This Procedure (Cont.):

	Include These Services In Your Work RVU Estimate (Only If You Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Intra-Service Work	<ul style="list-style-type: none"> • Direct the placement of hemodynamic ECG and pulse oximetry monitors. • Order I.V. antibiotics and conscious sedation. • Prep and drape patient. • Select and anesthetize approach site(s). • Position needle(s) and insert into collection(s). • Aspirate fluid (e.g. pus) and send for evaluation. • Inject contrast and pass guidewire(s) into collection(s). • Dilate tract over guidewire(s) and place appropriate size and configuration drainage catheter(s). • Aspirate and irrigate abscess(es). • Secure catheter(s) and place to gravity drainage. 	<ul style="list-style-type: none"> • Abdominal ultrasound to determine best approach to abscess, drainage needle insertion, for and confirmation of positioning (code 75989; RVW=1.19)
Routine Post-Service Work	<ul style="list-style-type: none"> • Write operative notes/orders. • Discuss results with patient, his/her family, and other physicians. • Daily ward rounds to assess patient, check catheter(s), irrigate tube(s), change dressings, etc. • Discharge of patient from hospital. • Post-hospital office visits. (Please report frequency and level of office visits on questionnaire.) • Remove catheter(s). 	<ul style="list-style-type: none"> • Contrast injection with imaging [codes 49XX1 (RVW=TBD) and 76080 (RVW=0.54)], <i>if performed.</i> • Exchange drainage catheter with imaging guidance [codes 49XX2 (RVW=TBD) and 75984 (RVW=0.72)], <i>if performed.</i> • Post drainage imaging (e.g. CT, ultrasound), <i>if performed.</i>

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION
American Society of Radiology
Society of Cardiovascular and Interventional Radiology

CPT Code: 4851X Tracking Number: K8 Global Period: 090 Recommended RVW: 10.00

CPT Descriptor: External drainage, pseudocyst of pancreas; percutaneous (for radiological supervision and interpretation, see 75989)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A forty-eight year old man with a history of alcoholism and pancreatitis presents with abdominal pain, fever, vomiting, and early satiety. A CT examination had previously revealed a 7 cm pseudocyst in the body of the pancreas, compressing the posterior wall of the stomach. A drainage catheter is placed. Catheter output is monitored daily. Resolution of the abscess is measured by clinical condition, imaging studies, and laboratory tests. The patient is followed as an outpatient and after complete resolution the catheter is removed.

Description of Pre-Service Work:

See Attachment

Description of Intra-Service Work:

See Attachment

Description of Post-Service Work:

See Attachment

SURVEY DATA:

Specialty: American College of RadiologySample Size: 110 Response Rate (%): N = 27 (25%) Median RVW: 10.025th Percentile RVW: 8.0 75th Percentile RVW: 11.5 Lowest RVW: 5.2 Highest RVW: 13.2Median Pre-Service Time: 30 minutes Median Intra-Service Time: 60 minutes25th Percentile Intra-Service Time: 50 minutes75th Percentile Intra-Service Time: 75 minutesLowest Intra-Service Time: 35 minutesHighest Intra-Service Time: 120 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>20</u>	
ICU:	<u>65</u>	<u>5</u>
Other Hospital:	<u>30</u>	<u>3</u>
Office:	<u>45</u>	<u>3</u>

Specialty: Society of Cardiovascular and Interventional RadiologySample Size: 76 Response Rate (%): 49% (N = 37) Median RVW: 1025th Percentile RVW: 8.6 75th Percentile RVW: 11.22 Lowest RVW: 5.1 Highest RVW: 14Median Pre-Service Time: 50 minutes Median Intra-Service Time: 65 minutes25th Percentile Intra-Service Time: 55 minutes75th Percentile Intra-Service Time: 90 minutesLowest Intra-Service Time: 30 minutesHighest Intra-Service Time: 120 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>30</u>	<u>2</u>
Other Hospital:	<u>60</u>	<u>4</u>
Office:	<u>60</u>	<u>4</u>

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>1996 (1997) RVW</u>	<u>Societies</u>
1) 47510	Introduction of percutaneous transhepatic catheter for biliary drainage	7.39 (7.39)	ACR/SCVIR
2) 47511	Introduction of percutaneous transhepatic stent or internal and external biliary drainage	9.91 (9.19)	SCVIR
3) 43750	Percutaneous placement of gastrostomy tube	5.71 (4.27)	SCVIR

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

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time		Median Intra-Time		Median Post-Time		Median Mental Effort & Judgment		Median Technical Skill & Physical Effort		Median Psychological Stress	
	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR
4851X	30	50	60	65	20	30	4	4	4	4	4	4
47511	NA	60	NA	100	NA	25	NA	4	NA	4	NA	4
47510	30	NA	75	NA	15	NA	3	NA	4	NA	4	NA
43750	NA	30	NA	45	NA	20	NA	3	NA	3	NA	3

	ACR	SCVIR
Number of times performed in last 12 months (median)	5	6
Agree with vignette?	Yes (100%, N=27)	Yes (86%, N=32) No (14%, N=5)

ADDITIONAL RATIONALE

The recommended RVW is based on the survey median RVWs from the ACR and the SCVIR, weighted by the number of survey respondents to the respective surveys.

FREQUENCY INFORMATION

How was this service previously reported? 48510

How often do physicians in your specialty perform this service?

Commonly X Sometimes Rarely

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

Is this service performed by many physicians across the United States? Yes X No

Clinical Description of Service and Vignette

Code 4851X: External drainage, pseudocyst of pancreas; percutaneous

Clinical Vignette: A forty-eight year old man with a history of alcoholism and pancreatitis presents with abdominal pain, fever, vomiting, and early satiety. A CT examination had previously revealed a 7 cm pseudocyst in the body of the pancreas, compressing the posterior wall of the stomach. A drainage catheter is placed. Catheter output is monitored daily. Resolution of the abscess is measured by clinical condition, imaging studies, and laboratory tests. The patient is followed as an outpatient and after complete resolution the catheter is removed.

Description of Physician Work Associated With This Procedure:

	Include These Services In Your Work RVU Estimate (Only If <u>You</u> Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Pre-Service Work	<ul style="list-style-type: none">• Review previous diagnostic studies, clinical findings, and laboratory data.• Examine patient• Explain risks, benefits, and alternatives to patient.• Obtain informed consent.• Discuss procedure with patient's family and other physicians.	

Code 4851X

Description of Physician Work Associated With This Procedure (Cont.):

	Include These Services In Your Work RVU Estimate (Only If <u>You</u> Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Intra-Service Work	<ul style="list-style-type: none"> • Direct the placement of hemodynamic ECG and pulse oximetry monitors. • Order I.V. antibiotics and conscious sedation. • Prep and drape patient. • Select and anesthetize approach site(s). • Position needle(s) and insert into collection(s). • Aspirate fluid (e.g. pus) and send for evaluation. • Pass guidewire(s) into collection(s). • Dilate tract over guidewire(s) and place appropriate size and configuration drainage catheter(s). • Aspirate and irrigate abscess(es). • Secure catheter(s) and place to gravity drainage. 	<ul style="list-style-type: none"> • Abdominal CT to determine best approach to abscess, drainage needle insertion, and for confirmation of positioning (code 75989; RVW=1.19)
Routine Post-Service Work	<ul style="list-style-type: none"> • Write operative notes/orders. • Discuss results with patient, his/her family, and other physicians. • Daily ward rounds to assess patient, check catheter(s), irrigate tube(s), change dressings, etc. • Discharge of patient from hospital. • Post-hospital office visits. (Please report frequency and level of office visits on questionnaire.) • Remove catheter(s). 	<ul style="list-style-type: none"> • Contrast injection with imaging [codes 49XX1 (RVW=TBD) and 76080 (RVW=0.54)], <i>if performed.</i> • Exchange drainage catheter with imaging guidance [codes 49XX2 (RVW=TBD) and 75984 (RVW=0.72)], <i>if performed.</i> • Post drainage imaging (e.g. CT, ultrasound), <i>if performed.</i>

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

Society of Cardiovascular & Interventional Radiology
American College of Radiology

CPT Code: 49021 Tracking Number: Global Period: 090 **Recommended RVW: 8.66**

CPT Descriptor: Drainage of peritoneal abscess or localized peritonitis; percutaneous (For radiological supervision and interpretation, see 75989)

CLINICAL DESCRIPTION OF SERVICE

Vignette Used in Survey:

A fifty-eight year old man, one week status-post Whipple procedure for pancreatic carcinoma, develops sepsis requiring intubation and pressor support. Abdominal CT examination reveals a 5 cm peritoneal abscess that is walled off from the indwelling surgical drains. Catheter drainage of the abscess is performed under combined ultrasound/fluoroscopic guidance. Catheter output is monitored daily. Resolution of the abscess is measured by clinical condition, imaging studies, and laboratory tests. The patient is followed as an outpatient and after complete resolution the catheter is removed.

Description of Pre-Service Work:

(See attachment)

Description of Intra-Service Work:

(See attachment)

Description of Post-Service Work:

(See attachment)

SURVEY DATASpecialty: Society of Cardiovascular & Interventional RadiologySample Size: 76 Response Rate: 49% (n=37) Median RVW: 8.8025th Percentile RVW: 7.00 75th Percentile RVW: 9.06 Low: 4.30 High: 12.00Median Pre-Service Time: 45 Median Intra-Service Time: 6025th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 80 Low: 30 High: 90Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
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Day of Procedure:	<u>30</u>	
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ICU:	<u>30</u>	<u>2</u>
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Other Hospital:	<u>50</u>	<u>4</u>
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Office:	<u>32.5</u>	<u>2</u>
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Specialty: American College of RadiologySample Size: 110 Response Rate: 24% (n=26) Median RVW: 8.4625th Percentile RVW: 6.05 75th Percentile RVW: 10.00 Low: 4.30 High: 11.00Median Pre-Service Time: 30 Median Intra-Service Time: 6025th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 60 Low: 30 High: 90Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
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Day of Procedure:	<u>22.5</u>	
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ICU:	<u>20</u>	<u>1.5</u>
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Other Hospital:	<u>50</u>	<u>5</u>
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Office:	<u>30</u>	<u>2</u>
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KEY REFERENCE SERVICES

	CPT Code	CPT Descriptor	RVW		Societies
			1996	1997	
1)	47510	Introduction of percutaneous transhepatic catheter for biliary drainage	7.39	7.39	SCVIR
2)	43750	Percutaneous placement of gastrostomy tube	5.71	4.27	SCVIR
3)	50392	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous	5.59	3.38	ACR

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICES

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time		Median Intra-Time		Median Post-Time		Median Mental Effort & Judgement		Median Technical Skill & Physical Effort		Median Psychological Stress	
	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR
49021	45	30	60	60	30	22.5	4	4	4	3.5	4	4
47510	50	n/a	90	n/a	30	n/a	4	n/a	4	n/a	4	n/a
43750	30	n/a	45	n/a	20	n/a	3	n/a	3	n/a	3	n/a
50392	n/a	30	n/a	60	n/a	17.5	n/a	3	n/a	3	n/a	4

	SCVIR	ACR
Number of times performed in last 12 months (median)	18	13
Agree with vignette?	92%	95%

ADDITIONAL RATIONALE

The recommended RVW is based on the survey median RVWs from the SCVIR and the ACR, weighted by the number of survey respondents to the respective surveys.

FREQUENCY INFORMATION

How was this service previously reported? 49020

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

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

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

Clinical Description of Service and Vignette

Code 49021: Drainage of peritoneal abscess or localized peritonitis; percutaneous, transabdominal

Clinical Vignette: A fifty-eight year old man, one week status-post Whipple procedure for pancreatic carcinoma, develops sepsis requiring intubation and pressor support. Abdominal CT examination reveals a 5 cm peritoneal abscess that is walled off from the indwelling surgical drains. Catheter drainage of the abscess is performed under combined ultrasound/fluoroscopic guidance. Catheter output is monitored daily. Resolution of the abscess is measured by clinical condition, imaging studies, and laboratory tests. The patient is followed as an outpatient and after complete resolution the catheter is removed.

Description of Physician Work Associated With This Procedure:

	Include These Services In Your Work RVU Estimate (Only If <u>You</u> Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Pre-Service Work	<ul style="list-style-type: none">• Review previous diagnostic studies, clinical findings, and laboratory data.• Examine patient• Explain risks, benefits, and alternatives to patient.• Obtain informed consent.• Discuss procedure with patient's family and other physicians.	

(Continued on next page)

Code 49021

Description of Physician Work Associated With This Procedure (Cont.):

	Include These Services In Your Work RVU Estimate (Only If You Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Intra-Service Work	<ul style="list-style-type: none"> • Direct the placement of hemodynamic ECG and pulse oximetry monitors. • Order I.V. antibiotics and conscious sedation. • Prep and drape patient. • Select and anesthetize approach site(s). • Position needle(s) and insert into collection(s). • Aspirate fluid (e.g. pus) and send for evaluation. • Pass guidewire(s) into collection(s). • Dilate tract over guidewire(s) and place appropriate size and configuration drainage catheter(s). • Aspirate and irrigate abscess(es). • Secure catheter(s) and place to gravity drainage. 	<ul style="list-style-type: none"> • Abdominal ultrasound to determine best approach to abscess, drainage needle insertion, and for confirmation of positioning. Fluoroscopy is used to direct guidewire into collection. (code 75989; RVW=1.19)
Routine Post-Service Work	<ul style="list-style-type: none"> • Write operative notes/orders. • Discuss results with patient, his/her family, and other physicians. • Daily ward rounds to assess patient, check catheter(s), irrigate tube(s), change dressings, etc. • Discharge of patient from hospital. • Post-hospital office visits. (Please report frequency and level of office visits on questionnaire.) • Remove catheter(s). 	<ul style="list-style-type: none"> • Contrast injection with imaging [codes 49XX1 (RVW=TBD) and 76080 (RVW=0.54)], <i>if performed.</i> • Exchange drainage catheter with imaging guidance [codes 49XX2 (RVW=TBD) and 75984 (RVW=0.72)], <i>if performed.</i> • Post drainage imaging (e.g. CT, ultrasound), <i>if performed.</i>

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION
American College of Radiology
Society of Cardiovascular and Interventional Radiology

CPT Code: 4904X Tracking Number: K10 Global Period: 090 Recommended RVW: 8.64

CPT Descriptor: Drainage of subdiaphragmatic or subphrenic abscess; percutaneous (For radiological supervision and interpretation, see 75989)

CLINICAL DESCRIPTION OF SERVICE:

A thirty-two year old woman, status post recent splenectomy for Hodgkin's lymphoma, presents with fever, leukopenia, left shoulder pain, and hiccups. A CT scan reveals a fluid collection in the splenic fossa with inflammatory changes extending into the bordering muscle, fascia, and subcutaneous tissues. Catheter drainage of the abscess is performed under combined ultrasound/fluoroscopic guidance. Catheter output is monitored daily. Resolution of the abscess is measured by clinical condition, imaging studies, and laboratory tests. The patient is followed as an outpatient and after complete resolution the catheter is removed.

Description of Pre-Service Work:

See Attachment

Description of Intra-Service Work:

See Attachment

Description of Post-Service Work:

See Attachment

SURVEY DATA:

Specialty: American College of RadiologySample Size: 110 Response Rate (%): N = 27 (25%) Median RVW: 8.525th Percentile RVW: 6.8 75th Percentile RVW: 9.5 Lowest RVW: 1.0 Highest RVW: 11Median Pre-Service Time: 30 minutes Median Intra-Service Time: 60 minutes25th Percentile Intra-Service Time: 40 minutes75th Percentile Intra-Service Time: 75 minutesLowest Intra-Service Time: 10 minutesHighest Intra-Service Time: 160 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>30</u>	<u>2</u>
Other Hospital:	<u>50</u>	<u>4</u>
Office:	<u>20</u>	<u>1</u>

Specialty: Society of Cardiovascular and Interventional RadiologySample Size: 76 Response Rate (%): 49% (N = 37) Median RVW: 8.7425th Percentile RVW: 7.2 75th Percentile RVW: 9.06 Lowest RVW: 5.2 Highest RVW: 11Median Pre-Service Time: 45 minutes Median Intra-Service Time: 60 minutes25th Percentile Intra-Service Time: 45 minutes75th Percentile Intra-Service Time: 75 minutesLowest Intra-Service Time: 30 minutesHighest Intra-Service Time: 120 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>25</u>	<u>1.75</u>
Other Hospital:	<u>50</u>	<u>4</u>
Office:	<u>30</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>1996 (1997) RVW</u>	<u>Societies</u>
1)	47510	Introduction of percutaneous transhepatic catheter for biliary drainage	7.39 (7.39)	SCVIR
2)	47511	Introduction of percutaneous transhepatic stent for internal and external biliary drainage	9.91 (9.11)	SCVIR
3)	50392	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous	5.59(3.38)	ACR

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

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time		Median Intra-Time		Median Post-Time		Median Mental Effort & Judgment		Median Technical Skill & Physical Effort		Median Psychological Stress	
	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR
4904X	30	45	60	60	30	30	4	4	4	4	4	4
47510	NA	50	NA	90	NA	30	NA	4	NA	4	NA	4
47511	NA	60	NA	100	NA	25	NA	4	NA	4	NA	4
50392	30	NA	55	NA	15	NA	3	NA	3	NA	3.5	NA

	ACR	SCVIR
Number of times performed in last 12 months (median)	5	9
Agree with vignette?	Yes (100%, N=27)	Yes (92%, N=34) No (8%, N=3)

ADDITIONAL RATIONALE

The recommended RVW is based on the survey median RVWs from the ACR and the SCVIR, weighted by the number of survey respondents to the respective surveys.

FREQUENCY INFORMATION

How was this service previously reported? 49040

How often do physicians in your specialty perform this service?

Commonly X Sometimes Rarely

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

Is this service performed by many physicians across the United States? Yes X No

Clinical Description of Service and Vignette

Code 4904X: Drainage of subdiaphragmatic or subphrenic abscess; percutaneous

Clinical Vignette: A thirty-two year old woman, status post recent splenectomy for Hodgkin's lymphoma, presents with fever, leukopenia, left shoulder pain, and hiccups. A CT scan reveals a fluid collection in the splenic fossa with inflammatory changes extending into the bordering muscle, fascia, and subcutaneous tissues. Catheter drainage of the abscess is performed under combined ultrasound/fluoroscopic guidance. Catheter output is monitored daily. Resolution of the abscess is measured by clinical condition, imaging studies, and laboratory tests. The patient is followed as an outpatient and after complete resolution the catheter is removed.

Description of Physician Work Associated With This Procedure:

	Include These Services In Your Work RVU Estimate (Only If <u>You</u> Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Pre-Service Work	<ul style="list-style-type: none">• Review previous diagnostic studies, clinical findings, and laboratory data.• Examine patient• Explain risks, benefits, and alternatives to patient.• Obtain informed consent.• Discuss procedure with patient's family and other physicians.	

Code 4904X

Description of Physician Work Associated With This Procedure (Cont.):

	Include These Services In Your Work RVU Estimate (Only If <u>You</u> Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Intra-Service Work	<ul style="list-style-type: none"> • Direct the placement of hemodynamic ECG and pulse oximetry monitors. • Order I.V. antibiotics and conscious sedation. • Prep and drape patient. • Select and anesthetize approach site(s). • Position needle(s) and insert into collection(s). • Aspirate fluid (e.g. pus) and send for evaluation. • Pass guidewire(s) into collection(s). • Dilate tract over guidewire(s) and place appropriate size and configuration drainage catheter(s). • Aspirate and irrigate abscess(es). • Secure catheter(s) and place to gravity drainage. 	<ul style="list-style-type: none"> • Abdominal ultrasound to determine best approach to abscess, drainage needle insertion, and for confirmation of positioning (code 75989; RVW=1.19).
Routine Post-Service Work	<ul style="list-style-type: none"> • Write operative notes/orders. • Discuss results with patient, his/her family, and other physicians. • Daily ward rounds to assess patient, check catheter(s), irrigate tube(s), change dressings; etc. • Discharge of patient from hospital. • Post-hospital office visits. (Please report frequency and level of office visits on questionnaire.) • Remove catheter(s). 	<ul style="list-style-type: none"> • Contrast injection with imaging [codes 49XX1 (RVW=TBD) and 76080 (RVW=0.54)], <i>if performed.</i> • Exchange drainage catheter with imaging guidance [codes 49XX2 (RVW=TBD) and 75984 (RVW=0.72)], <i>if performed.</i> • Post drainage imaging (e.g. CT, ultrasound), <i>if performed.</i>

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

Society of Cardiovascular & Interventional Radiology
American College of Radiology

CPT Code: 4906X Tracking Number: (K12) Global Period: 090 **Recommended RVW: 9.31**

CPT Descriptor: Drainage of retroperitoneal abscess; percutaneous (For radiological supervision and interpretation, see 75989)

CLINICAL DESCRIPTION OF SERVICE

Vignette Used in Survey:

A sixty-eight year old woman presents with back pain, leg weakness, and fever. CT examination reveals a destructive process at L3-L4 with extensive low-density collections involving the right psoas and iliacus muscles. Her PPD is positive. Anti-mycobacterial therapy is initiated, without clinical improvement. Drainage catheters are placed under CT guidance. Catheter output is monitored daily. Resolution of the abscess is measured by clinical condition, imaging studies, and laboratory tests. The patient is followed as an outpatient and after complete resolution the catheter is removed.

Description of Pre-Service Work:

(See attachment)

Description of Intra-Service Work:

(See attachment)

Description of Post-Service Work:

(See attachment)

SURVEY DATASpecialty: Society of Cardiovascular & Interventional RadiologySample Size: 76 Response Rate: 47% (n=36) Median RVW: 9.2525th Percentile RVW: 7.10 75th Percentile RVW: 10.50 Low: 5.00 High: 15.00Median Pre-Service Time: 45 Median Intra-Service Time: 6025th Percentile Intra-Svc Time: 58 75th Percentile Intra-Svc Time: 90 Low: 30 High: 110Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
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Day of Procedure:	<u>30</u>	
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ICU:	<u>20</u>	<u>1</u>
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Other Hospital:	<u>57.5</u>	<u>4</u>
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Office:	<u>35</u>	<u>2</u>
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Specialty: American College of RadiologySample Size: 110 Response Rate: 24% (n=26) Median RVW: 9.4025th Percentile RVW: 7.00 75th Percentile RVW: 10.55 Low: 1.00 High: 11.50Median Pre-Service Time: 30 Median Intra-Service Time: 6025th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 60 Low: 40 High: 110Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
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Day of Procedure:	<u>25</u>	
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ICU:	<u>22.5</u>	<u>2</u>
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Other Hospital:	<u>60</u>	<u>4</u>
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Office:	<u>25</u>	<u>2</u>
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KEY REFERENCE SERVICES

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>		<u>Societies</u>
			<u>1996</u>	<u>1997</u>	
1)	47511	Introduction of percutaneous transhepatic stent for internal and external biliary drainage	9.91	9.91	SCVIR
2)	47510	Introduction of percutaneous transhepatic catheter for biliary drainage	7.39	7.39	SCVIR
3)	50392	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous	5.59	3.38	ACR

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICES

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time		Median Intra-Time		Median Post-Time		Median Mental Effort & Judgement		Median Technical Skill & Physical Effort		Median Psychological Stress	
	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR
4906X	45	30	60	60	30	25	4	4	4	4	4	4
47511	60	n/a	100	n/a	25	n/a	4	n/a	4	n/a	4	n/a
47510	50	n/a	90	n/a	30	n/a	4	n/a	4	n/a	4	n/a
50392	n/a	30	n/a	55	n/a	15	n/a	3	n/a	3	n/a	3

	SCVIR	ACR
Number of times performed in last 12 months (median)	10	6
Agree with vignette?	86%	95%

ADDITIONAL RATIONALE

The recommended RVW is based on the survey median RVWs from the SCVIR and the ACR, weighted by the number of survey respondents to the respective surveys.

FREQUENCY INFORMATION

How was this service previously reported? 49060

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

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

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

Clinical Description of Service and Vignette

Code 4906X: Drainage of retroperitoneal abscess; percutaneous

Clinical Vignette: A sixty-eight year old woman presents with back pain, leg weakness, and fever. CT examination reveals a destructive process at L3-L4 with extensive low-density collections involving the right psoas and iliacus muscles. Her PPD is positive. Anti-mycobacterial therapy is initiated, without clinical improvement. Drainage catheters are placed under CT guidance. Catheter output is monitored daily. Resolution of the abscess is measured by clinical condition, imaging studies, and laboratory tests. The patient is followed as an outpatient and after complete resolution the catheter is removed.

Description of Physician Work Associated With This Procedure:

	Include These Services In Your Work RVU Estimate (Only If <u>You</u> Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Pre-Service Work	<ul style="list-style-type: none">• Review previous diagnostic studies, clinical findings, and laboratory data.• Examine patient• Explain risks, benefits, and alternatives to patient.• Obtain informed consent.• Discuss procedure with patient's family and other physicians.	

(Continued on next page)

Code 4906X

Description of Physician Work Associated With This Procedure (Cont.):

	Include These Services In Your Work RVU Estimate (Only If You Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Intra-Service Work	<ul style="list-style-type: none"> • Direct the placement of hemodynamic ECG and pulse oximetry monitors. • Order I.V. antibiotics and conscious sedation. • Prep and drape patient. • Select and anesthetize approach site(s). • Position needle(s) and insert into collection(s). • Aspirate fluid (e.g. pus) and send for evaluation. • Pass guidewire(s) into collection(s). • Dilate tract over guidewire(s) and place appropriate size and configuration drainage catheter(s). • Aspirate and irrigate abscess(es). • Secure catheter(s) and place to gravity drainage. 	<ul style="list-style-type: none"> • Abdominal CT to determine best approach to abscess, drainage needle insertion, and for confirmation of positioning (code 75989; RVW=1.19).
Routine Post-Service Work	<ul style="list-style-type: none"> • Write operative notes/orders. • Discuss results with patient, his/her family, and other physicians. • Daily ward rounds to assess patient, check catheter(s), irrigate tube(s), change dressings, etc. • Discharge of patient from hospital. • Post-hospital office visits. (Please report frequency and level of office visits on questionnaire.) • Remove catheter(s). 	<ul style="list-style-type: none"> • Contrast injection with imaging [codes 49XX1 (RVW=TBD) and 76080 (RVW=0.54)], <i>if performed.</i> • Exchange drainage catheter with imaging guidance [codes 49XX2 (RVW=TBD) and 75984 (RVW=0.72)], <i>if performed.</i> • Post drainage imaging (e.g. CT, ultrasound), <i>if performed.</i>

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION
American College of Radiology
Society of Cardiovascular and Interventional Radiology

CPT Code: 500XX Tracking Number: K14 Global Period: 090 Recommended RVW: 9.39

CPT Descriptor: Drainage of perirenal or renal abscess; percutaneous (For radiological supervision and interpretation, see 75989)

CLINICAL DESCRIPTION OF SERVICE:

A thirty-eight year old man presents with a 7 day history of fever, tachycardia, rigors, flank pain, and pyuria. CT had previously identified a renal pelvic calculus and a complex, low-density, gas-containing collection extending from the left upper pole into the perirenal space with extensive inflammation of the surrounding fascia and extension of the abscess into the anterior pararenal space. Drainage catheters are placed under CT guidance. Catheter output is monitored daily. Resolution of the abscess is measured by clinical condition, imaging studies, and laboratory tests. The patient is followed as an outpatient and after complete resolution the catheter is removed.

Description of Pre-Service Work:

See Attachment

Description of Intra-Service Work:

See Attachment

Description of Post-Service Work:

See Attachment

SURVEY DATA:

Specialty: American College of RadiologySample Size: 110 Response Rate (%): N = 28 (25%) Median RVW: 9.2525th Percentile RVW: 6.7 75th Percentile RVW: 11.11 Lowest RVW: 1.0 Highest RVW: 60Median Pre-Service Time: 30 minutes Median Intra-Service Time: 60 minutes25th Percentile Intra-Service Time: 45 minutes75th Percentile Intra-Service Time: 72.5 minutesLowest Intra-Service Time: 40 minutesHighest Intra-Service Time: 100 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>20</u>	
ICU:	<u>20</u>	<u>1</u>
Other Hospital:	<u>60</u>	<u>4</u>
Office:	<u>25</u>	<u>1.5</u>

Specialty: Society of Cardiovascular and Interventional RadiologySample Size: 76 Response Rate (%): 49% (N = 37) Median RVW: 9.525th Percentile RVW: 7.25 75th Percentile RVW: 11.5 Lowest RVW: 4.8 Highest RVW: 15Median Pre-Service Time: 45 minutes Median Intra-Service Time: 75 minutes25th Percentile Intra-Service Time: 60 minutes75th Percentile Intra-Service Time: 90 minutesLowest Intra-Service Time: 30 minutesHighest Intra-Service Time: 100 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>22.5</u>	<u>1</u>
Other Hospital:	<u>45</u>	<u>4</u>
Office:	<u>40</u>	<u>2</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>1996 (1997) RVW</u>	<u>Societies</u>
1)	47510	Introduction of percutaneous transhepatic catheter for biliary drainage	7.39 (7.39)	ACR/SCVIR
2)	50392	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection	5.59 (3.38)	SCVIR

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

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time		Median Intra-Time		Median Post-Time		Median Mental Effort & Judgment		Median Technical Skill & Physical Effort		Median Psychological Stress	
	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR
500XX	30	45	60	75	20	30	4	4	4	4	4	4
47510	37.5	30	82.5	90	22.5	30	3.5	4	4	4	4	4
50392	NA	25	NA	45	NA	20	NA	3	NA	3	NA	3

	ACR	SCVIR
Number of times performed in last 12 months (median)	4	6
Agree with vignette?	Yes (100%, N=28)	Yes (100%, N=28) No (5%, N=2)

ADDITIONAL RATIONALE

The recommended RVW is based on the survey median RVWs from the ACR and the SCVIR, weighted by the number of survey respondents to the respective surveys.

FREQUENCY INFORMATION

How was this service previously reported? 50020

How often do physicians in your specialty perform this service?

Commonly X Sometimes Rarely

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

Is this service performed by many physicians across the United States? Yes X No

Clinical Description of Service and Vignette

Code 500XX: Drainage of perirenal or renal abscess; percutaneous

Clinical Vignette: A thirty-eight year old man presents with a 7 day history of fever, tachycardia, rigors, flank pain, and pyuria. CT had previously identified a renal pelvic calculus and a complex, low-density, gas-containing collection extending from the left upper pole into the perirenal space with extensive inflammation of the surrounding fascia and extension of the abscess into the anterior pararenal space. Drainage catheters are placed under CT guidance. Catheter output is monitored daily. Resolution of the abscess is measured by clinical condition, imaging studies, and laboratory tests. The patient is followed as an outpatient and after complete resolution the catheter is removed.

Description of Physician Work Associated With This Procedure:

	Include These Services In Your Work RVU Estimate (Only If <u>You</u> Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Pre-Service Work	<ul style="list-style-type: none">• Review previous diagnostic studies, clinical findings, and laboratory data.• Examine patient• Explain risks, benefits, and alternatives to patient.• Obtain informed consent.• Discuss procedure with patient's family and other physicians.	

Code 500XX

Description of Physician Work Associated With This Procedure (Cont.):

	Include These Services In Your Work RVU Estimate (Only If <u>You</u> Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Intra-Service Work	<ul style="list-style-type: none"> • Direct the placement of hemodynamic ECG and pulse oximetry monitors. • Order I.V. antibiotics and conscious sedation. • Prep and drape patient. • Select and anesthetize approach site(s). • Position needle(s) and insert into collection(s). • Aspirate fluid (e.g. pus) and send for evaluation. • Pass guidewire(s) into collection(s). • Dilate tract over guidewire(s) and place appropriate size and configuration drainage catheter(s). • Aspirate and irrigate abscess(es). • Secure catheter(s) and place to gravity drainage. 	<ul style="list-style-type: none"> • Abdominal CT to determine best approach to abscess, drainage needle insertion, and for confirmation of positioning (code 75989; RVW=1.19).
Routine Post-Service Work	<ul style="list-style-type: none"> • Write operative notes/orders. • Discuss results with patient, his/her family, and other physicians. • Daily ward rounds to assess patient, check catheter(s), irrigate tube(s), change dressings, etc. • Discharge of patient from hospital. • Post-hospital office visits. (Please report frequency and level of office visits on questionnaire.) • Remove catheter(s). 	<ul style="list-style-type: none"> • Contrast injection with imaging [codes 49XX1 (RVW=TBD) and 76080 (RVW=0.54)], <i>if performed.</i> • Exchange drainage catheter with imaging guidance [codes 49XX2 (RVW=TBD) and 75984 (RVW=0.72)], <i>if performed.</i> • Post drainage imaging (e.g. CT, ultrasound), <i>if performed.</i>

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION
American College of Radiology
Society of Cardiovascular and Interventional Radiology
American College of Obstetricians and Gynecologists

CPT Code: 588XX Tracking Number: K17 Global Period: 090 Recommended RVW:

CPT Descriptor: Drainage of pelvic abscess, transvaginal or transrectal approach; percutaneous (e.g. ovarian, pericolic) (For radiological supervision and interpretation, see 75989)

CLINICAL DESCRIPTION OF SERVICE:

A twenty-five year old woman with pelvic pain, fever, and clinical signs of sepsis. An ultrasound examination reveals a complex cystic collection involving the right fallopian tube and ovary. The left ovary is surgically absent as a result of a prior infection. Catheter drainage of the collection is performed under combined ultrasound/fluoroscopic guidance. Catheter output is monitored daily. Resolution of the abscess is measured by clinical condition, imaging studies, and laboratory tests. The patient is followed as an outpatient and after complete resolution the catheter is removed.

Description of Pre-Service Work:

See Attachment

Description of Intra-Service Work:

See Attachment

Description of Post-Service Work:

See Attachment

SURVEY DATA:

Specialty: American College of RadiologySample Size: 110 Response Rate (%): N = 24 (22%) Median RVW: 7.7525th Percentile RVW: 6.0 75th Percentile RVW: 9.28 Lowest RVW: 3.96 Highest RVW: 12Median Pre-Service Time: 30 minutes Median Intra-Service Time: 60 minutes25th Percentile Intra-Service Time: 50 minutes75th Percentile Intra-Service Time: 77.5 minutesLowest Intra-Service Time: 30 minutesHighest Intra-Service Time: 100 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>20</u>	
ICU:	<u>20</u>	<u>1</u>
Other Hospital:	<u>50</u>	<u>4</u>
Office:	<u>20</u>	<u>1</u>

Specialty: Society of Cardiovascular and Interventional RadiologySample Size: 76 Response Rate (%): 42% (N = 32) Median RVW: 7.1325th Percentile RVW: 5.95 75th Percentile RVW: 8.5 Lowest RVW: 3 Highest RVW: 12.5Median Pre-Service Time: 45 minutes Median Intra-Service Time: 60 minutes25th Percentile Intra-Service Time: 56 minutes75th Percentile Intra-Service Time: 90 minutesLowest Intra-Service Time: 30 minutesHighest Intra-Service Time: 100 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>15</u>	<u>0.35</u>
Other Hospital:	<u>50</u>	<u>4</u>
Office:	<u>30</u>	<u>2</u>

Specialty: American College of Obstetricians and GynecologistsSample Size: 35 Response Rate (%): N=13 (37%) Median RVW: 4.2825th Percentile RVW: 4.12 75th Percentile RVW: 4.75 Lowest RVW: 3.5 Highest RVW: 7Median Pre-Service Time: 60 minutes Median Intra-Service Time: 45 minutes25th Percentile Intra-Service Time: 40 minutes75th Percentile Intra-Service Time: 60 minutesLowest Intra-Service Time: 0 minutesHighest Intra-Service Time: 120 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>20</u>	
ICU:	<u></u>	<u></u>
Other Hospital:	<u>60</u>	<u>5</u>
Office:	<u>45</u>	<u>35</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>1996 (1997) RVW</u>	<u>Societies</u>
1)	47510	Introduction of percutaneous transhepatic catheter for biliary drainage	7.39 (7.39)	ACR/SCVIR
2)	43750	Percutaneous placement of Gastrostomy tube	5.71(4.27)	SCVIR
3)	58820	Drainage of ovarian abscess; vaginal approach	3.96 (3.96)	ACOG
4)	45000	Transrectal drainage of pelvic abscess	4.28(4.28)	ACOG
5)	57010	Colpotomy; with drainage of pelvic abscess	5.41 (5.41)	ACOG
6)	57020	Colpocentesis (separate procedure)	1.5 (1.5)	ACOG
7)	58822	Drainage of ovarian abscess; abdominal approach	6.18 (9.06)	ACOG

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

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time		Median Intra-Time		Median Post-Time		Median Mental Effort & Judgment		Median Technical Skill & Physical Effort		Median Psychological Stress	
	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR
588XX	30	45	60	60	20	30	4	4	4	4	4	4
47510	45	50	90	90	45	30	4	4	4	4	5	4
43750	NA	30	NA	45	NA	20	NA	3	NA	3	NA	3

ACOG

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgment	Median Technical Skill & Physical Effort	Median Psychological Stress
588XX	60	45	20	4	3	3
58820	60	40	25	3.5	3	3
45000	45	45	20	4	3	3.5
57010	120	67.5	30	3	3	3
57020	30	20	15	2	2	2
58822	75	75	30	4.5	4.5	3

	ACR	SCVIR	ACOG
Number of times performed in last 12 months (median)	3	5	1
Agree with vignette?	Yes (100%, N=28)	Yes (78%, N=25) No (22%, N=7)	Yes (92%, N=12) No (7%, N=1)

ADDITIONAL RATIONALE

FREQUENCY INFORMATION

How was this service previously reported? 58820

How often do physicians in your specialty perform this service?

Commonly X Sometimes Rarely Estimate the number of times this service might be performed nationally in a one-year period? Is this service performed by many physicians across the United States? Yes X No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION
American College of Radiology
Society of Cardiovascular and Interventional Radiology

CPT Code: 49XX1 Tracking Number: K18 Global Period: 000 Recommended RVW: 0.83

CPT Descriptor: Contrast injection for assessment of abscess or cyst via previously placed catheter (separate procedure) (For radiological supervision and interpretation, see 76080)

CLINICAL DESCRIPTION OF SERVICE:

A sixty-five year old man with a previously drained postoperative abdominal abscess is seen. Catheter output has recently changed; after having decreased to 15-20 ml/day, three days after drainage, the output has markedly increased to 80-100 cc/day. The patient is afebrile. The drainage catheter is injected with contrast to document the size of the abscess cavity and the presence or absence of fistulae to bowel or adjacent structures.

Description of Pre-Service Work:

See Attachment

Description of Intra-Service Work:

See Attachment

Description of Post-Service Work:

See Attachment

SURVEY DATA:

Specialty: American College of RadiologySample Size: 110 Response Rate (%): 26% (N = 29) Median RVW: 0.9025th Percentile RVW: 0.80 75th Percentile RVW: 1.10 Lowest RVW: 0.62 Highest RVW: 3.61Median Pre-Service Time: 10 minutes Median Intra-Service Time: 15 minutes25th Percentile Intra-Service Time: 10 minutes75th Percentile Intra-Service Time: 20 minutesLowest Intra-Service Time: 10 minutesHighest Intra-Service Time: 30 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>10</u>	
ICU:	<u>0</u>	<u>0</u>
Other Hospital:	<u>0</u>	<u>0</u>
Office:	<u>0</u>	<u>0</u>

Specialty: Society of Cardiovascular and Interventional RadiologySample Size: 76 Response Rate (%): 47% (N = 36) Median RVW: 0.7825th Percentile RVW: 0.76 75th Percentile RVW: 0.9625 Lowest RVW: 0.75 Highest RVW: 2Median Pre-Service Time: 15 minutes Median Intra-Service Time: 15 minutes25th Percentile Intra-Service Time: 10 minutes75th Percentile Intra-Service Time: 30 minutesLowest Intra-Service Time: 0 minutesHighest Intra-Service Time: 45 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>10</u>	
ICU:	<u>0</u>	<u>0</u>
Other Hospital:	<u>0</u>	<u>0</u>
Office:	<u>0</u>	<u>0</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>1996 (1997) RVW</u>	<u>Societies</u>
1)	47505	Injection procedure for cholangiography through an existing catheter (eg, percutaneous transhepatic or T-tube)	0.76 (0.76)	SCVIR
2)	20501	Injection of sinus tract; diagnostic (sinogram)	0.76 (0.76)	SCVIR
3)	50394	Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter.	0.76(0.76)	ACR
4)	47500	Injection procedure for percutaneous transhepatic cholangiography	1.96 (1.96)	ACR
5)	51600	Injection procedure for cystography or voiding urethrocystography	0.88 (0.88)	ACR

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

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time		Median Intra-Time		Median Post-Time		Median Mental Effort & Judgment		Median Technical Skill & Physical Effort		Median Psychological Stress	
	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR
49XX1	10	15	15	15	10	10	2	2	2	2	2	2
47505	NA	12.5	NA	20	NA	7.5	NA	2	NA	1.5	NA	1
20501	NA	15	NA	17.5	NA	7.5	NA	2	NA	2	NA	2
50394	10	NA	15	NA	10	NA	1.5	NA	1.5	NA	1.5	NA
47500	20	NA	25	NA	15	NA	3	NA	3	NA	3	NA
51600	10	NA	15	NA	10	NA	2	NA	2	NA	2	NA

	ACR	SCVIR
Number of times performed in last 12 months (median)	35	40
Agree with vignette?	Yes (95%, N=20) No (5%, N=1)	Yes (97%, N=35) No (3%, N=1)

ADDITIONAL RATIONALE

The recommended RVW is based on the survey median RVWs from the ACR and the SCVIR, weighted by the number of survey respondents to the respective surveys.

FREQUENCY INFORMATION

How was this service previously reported? _____

How often do physicians in your specialty perform this service?

Commonly X Sometimes Rarely

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

Is this service performed by many physicians across the United States? Yes X No

Clinical Description of Service and Vignette

Code 588XX: Drainage of pelvic abscess, transvaginal or transrectal approach; percutaneous (e.g. ovarian, pericolic)

Clinical Vignette: A twenty-five year old woman with pelvic pain, fever, and clinical signs of sepsis. An ultrasound examination reveals a complex cystic collection involving the right fallopian tube and ovary. The left ovary is surgically absent as a result of a prior infection. Catheter drainage of the collection is performed under combined ultrasound/fluoroscopic guidance. Catheter output is monitored daily. Resolution of the abscess is measured by clinical condition, imaging studies, and laboratory tests. The patient is followed as an outpatient and after complete resolution the catheter is removed.

Description of Physician Work Associated With This Procedure:

	Include These Services In Your Work RVU Estimate (Only If <u>You</u> Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Pre-Service Work	<ul style="list-style-type: none">• Review previous diagnostic studies, clinical findings, and laboratory data.• Examine patient• Explain risks, benefits, and alternatives to patient.• Obtain informed consent.• Discuss procedure with patient's family and other physicians.	

Code 588XX

Description of Physician Work Associated With This Procedure (Cont.):

	Include These Services In Your Work RVU Estimate (Only If <u>You</u> Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Intra-Service Work	<ul style="list-style-type: none"> • Direct the placement of hemodynamic ECG and pulse oximetry monitors. • Order I.V. antibiotics and conscious sedation. • Prep and drape patient. • Select and anesthetize approach site(s). • Position needle(s) and insert into collection(s). • Aspirate fluid (e.g. pus) and send for evaluation. • Pass guidewire(s) into collection(s). • Dilate tract over guidewire(s) and place appropriate size and configuration drainage catheter(s). • Aspirate and irrigate abscess(es). • Secure catheter(s) and place to gravity drainage. 	<ul style="list-style-type: none"> • Abdominal ultrasound to determine best approach to abscess, drainage needle insertion, and for confirmation of positioning (code 75989; RVW=1.19).
Routine Post-Service Work	<ul style="list-style-type: none"> • Write operative notes/orders. • Discuss results with patient, his/her family, and other physicians. • Daily ward rounds to assess patient, check catheter(s), irrigate tube(s), change dressings, etc. • Discharge of patient from hospital. • Post-hospital office visits. (Please report frequency and level of office visits on questionnaire.) • Remove catheter(s). 	<ul style="list-style-type: none"> • Contrast injection with imaging [codes 49XX1 (RVW=TBD) and 76080 (RVW=0.54)], <i>if performed</i>. • Exchange drainage catheter with imaging guidance [codes 49XX2 (RVW=TBD) and 75984 (RVW=0.72)], <i>if performed</i>. • Post drainage imaging (e.g. CT, ultrasound), <i>if performed</i>.

Clinical Description of Service and Vignette

Code 49XX1: Contrast injection for assessment of abscess or cyst via previously placed catheter (separate procedure)

Clinical Vignette: A sixty-five year old man with a previously drained postoperative abdominal abscess is seen. Catheter output has recently changed; after having decreased to 15-20 ml/day, three days after drainage, the output has markedly increased to 80-100 cc/day. The patient is afebrile. The drainage catheter is injected with contrast to document the size of the abscess cavity and the presence or absence of fistulae to bowel or adjacent structures.

Note: This code is not intended to be used at the time of original percutaneous or open abscess drainage either by the same physician or a different physician. It also can be used for diagnostic evaluation of patients with previously performed percutaneous or open abscess drainages.

Description of Physician Work Associated With This Procedure:

	Include These Services In Your Work RVU Estimate (Only If <u>You</u> Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Pre-Service Work	<ul style="list-style-type: none">• Review previous diagnostic studies, clinical findings, and laboratory data.• Examine patient	
Intra-Service Work	<ul style="list-style-type: none">• Direct the placement of hemodynamic ECG and pulse oximetry monitors.• Order I.V. antibiotics and conscious sedation.• Prep and drape patient.• Inject contrast material into cavity.	<ul style="list-style-type: none">• The flow of contrast material and filling of the cavity are observed. fluoroscopically and spot films in multiple projections are obtained to document cavity size and presence or absence of fistulae (code 76080; RVW=0.54).
Post-Service Work	<ul style="list-style-type: none">• Re-secure catheter to skin and attach drainage bag.• Write operative notes/orders.	

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

Society of Cardiovascular & Interventional Radiology
American College of Radiology

CPT Code: 49XX2 Tracking Number: (K19) Global Period: 000 Recommended RVW: 2.72

CPT Descriptor: Exchange of previously placed abscess or cyst drainage catheter under radiological guidance
(separate procedure) (For radiological supervision and interpretation, see 75984)

CLINICAL DESCRIPTION OF SERVICE

Vignette Used in Survey:

A fifty-three year old man with a long history of pancreatitis and extended drainage of a complex pancreatic abscess/pseudocyst is seen as an outpatient. His catheter output that had been 50 ml/day has reduced dramatically. He is now febrile and has upper abdominal pain and tenderness. The catheter is aspirated and injected with saline; the catheter is occluded. The pseudocyst has become loculated and a second chamber only fills through a small channel. The catheter is exchanged over a guidewire and selective catheters and guidewires are used to cannulate the small tract between the two locules. Ultimately, the loculated cavity is entered and a catheter is placed for drainage. Another catheter is positioned in the original cavity.

Description of Pre-Service Work:

(See attachment)

Description of Intra-Service Work:

(See attachment)

Description of Post-Service Work:

(See attachment)

SURVEY DATASpecialty: Society of Cardiovascular & Interventional RadiologySample Size: 76 Response Rate: 49% (n=37) Median RVW: 2.5025th Percentile RVW: 1.70 75th Percentile RVW: 4.00 Low: 0.95 High: 8.00Median Pre-Service Time: 15 Median Intra-Service Time: 3025th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 45 Low: 0 High: 60Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
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Day of Procedure:	<u>15</u>	
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ICU:	<u>0</u>	<u>0</u>
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Other Hospital:	<u>5</u>	<u>0</u>
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Office:	<u>0</u>	<u>0</u>
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Specialty: American College of RadiologySample Size: 110 Response Rate: 26% (n=29) Median RVW: 3.0025th Percentile RVW: 1.70 75th Percentile RVW: 5.00 Low: 0.72 High: 7.22Median Pre-Service Time: 15 Median Intra-Service Time: 3025th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 45 Low: 15 High: 60Median Post-Service Time:

	<u>Total Time</u>	<u>Number of Visits</u>
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Day of Procedure:	<u>15</u>	
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ICU:	<u>15</u>	<u>1</u>
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Other Hospital:	<u>20</u>	<u>2</u>
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Office:	<u>30</u>	<u>2</u>
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KEY REFERENCE SERVICES

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>		<u>Societies</u>
			<u>1996</u>	<u>1997</u>	
1)	50398	Change of nephrostomy or pyelostomy tube	1.46	1.46	SCVIR
2)	47525	Change of percutaneous biliary drainage catheter	5.41	5.41	SCVIR
3)	75984	Change of percutaneous tube or drainage catheter with contrast monitoring, radiological supervision and interpretation	0.72	0.72	ACR

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICES

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time		Median Intra-Time		Median Post-Time		Median Mental Effort & Judgement		Median Technical Skill & Physical Effort		Median Psychological Stress	
	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR	SCVIR	ACR
49XX2	15	15	30	30	15	15	3	3	3	3	3	3
50398	10	n/a	20	n/a	10	n/a	2	n/a	2	n/a	2	n/a
47525	15	n/a	30	n/a	1	n/a	3	n/a	3	n/a	3	n/a
75984	n/a	7.5	n/a	20	n/a	10	n/a	2	n/a	2	n/a	1.5

	SCVIR	ACR
Number of times performed in last 12 months (median)	20	20
Agree with vignette?	89%	89%

ADDITIONAL RATIONALE

The recommended RVW is based on the survey median RVWs from the SCVIR and the ACR, weighted by the number of survey respondents to the respective surveys.

FREQUENCY INFORMATION

How was this service previously reported? 47525

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

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

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

Clinical Description of Service and Vignette

Code 49XX2: **Exchange of previously placed abscess or cyst drainage catheter under radiologic guidance (separate procedure)**

Clinical Vignette: A fifty-three year old man with a long history of pancreatitis and extended drainage of a complex pancreatic abscess/pseudocyst is seen as an outpatient. His catheter output that had been 50 ml/day has reduced dramatically. He is now febrile and has upper abdominal pain and tenderness. The catheter is aspirated and injected with saline; the catheter is occluded. The pseudocyst has become loculated and a second chamber only fills through a small channel. The catheter is exchanged over a guidewire and selective catheters and guidewires are used to cannulate the small tract between the two locules. Ultimately, the loculated cavity is entered and a catheter is placed for drainage. Another catheter is positioned in the original cavity.

Note: This code is not intended to be used at the time of original percutaneous or open abscess drainage either by the same physician or a different physician. It also can be used for diagnostic evaluation of patients with previously performed percutaneous or open abscess drainages.

Description of Physician Work Associated With This Procedure:

	Include These Services In Your Work RVU Estimate (Only If <u>You</u> Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Pre-Service Work	<ul style="list-style-type: none">• Review previous diagnostic studies, clinical findings, and laboratory data.• Examine patient.• Explain procedure to patient and obtain informed consent.	

(Continued on next page)

Code 49XX2**Description of Physician Work Associated With This Procedure (Cont.):**

	Include These Services In Your Work RVU Estimate (Only If <u>You</u> Perform Them)	Exclude These Services in Your Work RVU Estimate (These services are separately reportable.)
Intra-Service Work	<ul style="list-style-type: none">• Prep and drape patient.• Order local anesthesia and intravenous sedation.• Catheter is irrigated free of inspissated debris from pseudocyst.• The catheter is withdrawn and a guidewire and sheath are placed into cavity.• An appropriate size and configuration catheter is placed over the guidewire into the loculated cavity.• Fluid is aspirated from collection and sent for evaluation.• An appropriate size and configuration catheter is placed in the original cavity.• The catheter is secured in place.	<ul style="list-style-type: none">• Contrast is injected into catheter (code 49XX1; RVW=TBD).• Multiple views of the cavity shows minimal filling of a locule that has become segmented from the original pseudocyst (code 76080; RVW=0.54).• Fluoroscopy is used to place the guidewire over which a new catheter is placed into cavity (code 75984; RVW= 0.72).
Post-Service Work	<ul style="list-style-type: none">• Discuss findings and procedure with patient, his/her family, and referring physician.• Patient is discharged after observation period.• Write operative notes/orders.• Schedule follow-up visit.	

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
FEBRUARY 1997

Closure of Colostomy - Tab 17

A new CPT code 44626 combines the work involved in a Hartmann's procedure with the closure of a colostomy. The new procedure is usually performed on patients that have previously undergone the Hartmann's colostomy. The Hartmann's procedure that is described by CPT code 44143 involves a partial colectomy and closure of the distal segment of the colon. The Hartmann's colostomy is characterized by the removal of a lesion on the colon and the oversewing of the rectum. The disadvantage of the Hartmann's is that patients often experience loss of bowel function. The new closure of colostomy procedure restores bowel function in many patients however, since this surgery is considered a secondary resection it is often very difficult. This new procedure involves mobilization of the splenic flexure that is not usually part of a colostomy closure. The typical patient that undergoes this procedure has a diagnosis of perforated diverticulitis or obstructing colon cancer. At the time of surgery, many patients are experiencing peritonitis resulting in severe inflammation and adhesions which greatly increases the difficulty of the surgery. In female patients the surgery is complicated by the possibility of injury to the vaginal area.

This procedure was previously reported as CPT code 44145 *Colectomy, partial; with coloproctostomy (low pelvic anastomosis)* (work RVU = 21.29) or 44625 *Closure of enterostomy, large or small intestine; with resection and anastomosis* (work RVU = 12.10). The RUC agreed with the specialty society contention that the survey median was too low and accepted the specialty society recommendation of 21.29 RVUs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
44620		<i>Closure of enterostomy, large or small intestine;</i>	090	9.65 (no change)
44625	L1	with resection and anastomosis <u>other than</u> <u>colorectal</u>	090	12.10 (no change)
•44626	L2	with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)	090	21.29

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 446XX Tracking Number: L 2 Global Period: 090 Recommended RVW: 21.29

CPT Descriptor: Closure of Colostomy with Colorectal anastomosis.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: : A 73 yr old male with colostomy from a Hartmann's procedure undergoes colostomy closure. The operation entails re-exploration of the abdomen with mobilization of the intestine from the pelvis. The colostomy site is dissected from the abdominal wall and the colon is mobilized proximal to the splenic flexure. The colostomy site is resected. An anastomosis is performed from the colon to the rectum after isolation of the rectum in the pelvis. The abdominal incision and colostomy site are closed in layers. Postoperative care manages the associated ileus and wound care. Outpatient followup includes assessment for anastomotic complications.

Description of Pre-Service Work: Perform and review a complete history, physical and preoperative lab, X-ray and ECG profile. Counsel the patient and family about the operation. After induction of anesthesia, place the patient in the lithotomy position, protect and pad the extremities from injury with sequential compression stockings. Place an foley catheter in the bladder. Place a rectal catheter into the anus and irrigate the rectum with 3 liters, until clear. Prepare the surgical site with antibiotic scrub. Surgical scrub, gown, prep and drape patient.

Description of Intra-Service Work: Through a midline incision, explore the abdomen. The previous operation typically involves pelvic sepsis and creates dense adhesions that maximally complicate the re-exploration. First, identify the remaining rectum. Parastomal incision affords the initial stoma mobilization. The stoma is dissected free from the anterior abdominal wall fascia. Mobilize the colon from the midtransverse colon distally including the splenic flexure. The descending colon will serve as the segment for the anastomosis. The ureters are identified bilaterally with care to prevent injury. A hand sewn anastomosis is performed. While the pelvis is filled with irrigation, a rigid proctoscopy is performed with insufflation of the rectum to assure that the anastomosis does not create an air leak and remains intact. The stoma site is closed in two layers - anterior and posterior fascia. The abdominal wound is also closed in layers.

Description of Post-Service Work: The surgeon documents the operative procedure and develops the postoperative orders. Counsel the immediate family about the conduct of surgery, the expected care and outcomes. During the remaining seven hospital days, twice daily visits evaluate and manage the postanesthetic cardiopulmonary and renal status, wound drainage, pain management and the intestinal function. Three outpatient visits for assessment of wound, evidence of infection, and pain management.

SURVEY DATA:

Specialty: American Society of Colon and Rectal Surgeons

Sample Size: 80 Response Rate (%): 40% Median RVW: 19.50

25th Percentile RVW: 17.00 75th Percentile RVW: 21.00 Low: 12.50 High: 25.00

Median Pre-Service Time: 60 Median Intra-Service Time: 180

25th Percentile Intra-Svc Time: 128 75th Percentile Intra-Svc Time: 180 Low: 60 High: 240

Median Post-Service Time:

Total Time

of Visits

CPT Code: 446XX

Day of Procedure:

30

ICU:

Other Hospital:

77.507.0

Office:

42.503.0**KEY REFERENCE SERVICE(S):**

CPT CODE	[N]	CPT DESCRIPTOR	PRE (MIN)	INTRA (MIN)	POST (MIN)	RVW	M.E.	T.S.	P.S.
446XX	32	Colostomy Closure	60	180	150	21.29	3.5	4	4
44145	26	Low Anterior Resection	60	180	165	21.29	4	4	4

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Reference 44145 (21.29) is similar to the surveyed code in pre and postservice time and work. The intraservice differences detail the difficulty in excising a colostomy site. The abdominal adhesions and resection of the colostomy are more difficult than the resection of the rectosigmoid (a component of 44145). The rectal dissection in a low anterior resection equals the mobilization of the Hartmann's pouch that lies buried in cicatrix within the pelvis. 446XX has increased work for after completing the colostomy excision and anastomosis - the colostomy site must be closed.

ADDITIONAL RATIONALE

Closure of a colostomy is similar to 44145 as noted above, but it also involves the closure of the stoma site. The colostomy site closure closely approximates an average incisional herniorraphy (49560; RVw = 9.48). The ASCRS committee feels that the survey respondents did not consider the dense inflammation and adhesions encountered in colostomy closure. The committee also feels that the closure of the colostomy site itself also deserves valuation. The committee believes the survey respondents often consider all operations as the "best case" scenario, that is, surgery without complications. Yet, the typical colostomy closure is complicated particularly with stomal site wound infections. Although the intraoperative work of 446XX exceeds the work of 44145; this is balanced by the increased postoperative work in 44145. 44145 typically involves a septic patient who requires ICU care for 1-5 days. Thus, the ASCRS feels that the total work for the two codes is comparable.

FREQUENCY INFORMATIONHow was this service previously reported? Reported as 44145How often do physicians in your specialty perform this service? X Commonly X Sometimes RarelyEstimate the number of times this service might be provided nationally in a one-year period? 20,000Is this service performed by many physicians across the United States? Yes X No

General Surgeons and Colorectal surgeons

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
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Proctectomy with Coloanal Anastomosis - Tab 18

A new CPT code 45119 was established to report a proctocolectomy with reservoir. This is a new procedure that is being performed on a limited basis in colorectal tertiary centers. This procedure is done to restore colonic reservoir which has been damaged due to disease, usually rectal cancer or extensive rectal polyposis. The ability for a surgeon to perform a proctocolectomy with reservoir is due to a better understanding of physiology and reduces the chance that post-op patients will be left with severe bowel dysfunction.

During this procedure the entire colon is rotated on a vascular pedicle and then secured to the anal canal by anastomosis. The procedure also includes formation of a loop ileostomy. This operation is long and requires an ICU stay to manage post-op complications in particular, fluid shifts. The work described by 45119 is similar in nature to 44153 *Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy* (work RVU = 24.69), except that 44153 requires the resection of the entire colon and the creation of an ileal J-Pouch. 45119 is currently reported as 45112 *Proctectomy, combined abdominoperineal, pull through procedure (eg colo-anal anastomosis)* (work RVU = 24.02) with a -22 modifier appended to the code. The RUC accepted the specialty society recommendation of 23.50 RVUs for 45119 which represents the survey median.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•45119	M1	Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg. J-pouch), with or without proximal diverting ostomy	090	23.50

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 4511X Tracking Number: M 1 Global Period: 090 Recommended RVW: 23.50

CPT Descriptor: Proctectomy, combined abdominoperineal pull through procedure, (ie coloanal anastomosis), with creation of a colonic reservoir, (ie J-Pouch), with or without proximal diverting ostomy.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: : A 53 yr old female requires radical extirpation of a 4cm rectal cancer with a resection margin at the level of the levators. A total mesorectal resection with proctectomy is performed. The remaining colon is mobilized proximal to the splenic flexure. A colonic J-Pouch is fashioned in the descending colon. The J-Pouch anastomosis to the rectum is either through a transanal or abdominal approach. A diverting loop ileostomy in the right lower quadrant protects the anastomosis. Close the abdominal incision. Postoperative care manages the associated ileus and wound care. Outpatient followup includes assessment for anastomotic complications.

Description of Pre-Service Work: Perform and review a complete history, physical and preoperative lab, X-ray and ECG profile. Counsel the patient and family about the operation and intraoperative decisions - with special attention to malignant disease, treatment options, and preparation for life with a temporary/permanent stoma. Preoperative care coordination with oncologist and radiation therapist. The surgeon marks the patient preoperative for placement of a stoma with indelible ink. After induction of anesthesia, place the patient in the lithotomy position, protect and pad the extremities from injury with sequential compression stockings. Place an foley catheter in the bladder. Place a rectal catheter into the anus and irrigate the rectum with 3 liters, until clear. Prepare the surgical site with antibiotic scrub. Surgical scrub, gown, prep and drape patient.

Description of Intra-Service Work: Through a midline incision, explore the abdomen. Establish the intraoperative staging of the rectal cancer assessing for extra pelvic extension of the tumor. Mobilize the colon from the midtransverse colon distally including the splenic flexure. The descending colon will serve as the segment for creation of the J-Pouch. The sigmoid colon is resected enbloc with the rectum. A total mesorectal excision is included to provide adequate margins for a malignancy. The ureters are identified bilaterally with care to prevent injury. The rectosigmoid segment is resected and removed from the operative field. The specimen is forwarded to the pathologist where it is properly opened and thus, allows the surgeon to establish the adequacy of the distal margin. The J-Pouch is created using a linear gastrointestinal stapler. The anorectal junction is prepared by placing circumferential sutures transanally. The J-Pouch is introduced into the pelvis and advanced to the anorectal junction. A hand sewn, transanal anastomosis is performed. The previously marked ileostomy site is identified in the right lower quadrant. The ileostomy is prepared by incising the skin and opening the rectus fascia. The rectus muscles are split and the posterior fascia is incised. The terminal ileum is brought out through the ileostomy site. A stoma bar is placed beneath the ileostomy to prevent stoma retraction. Two active drains are placed within the pelvis and the abdominal incision is closed. The ileostomy is matured to the stoma.

Description of Post-Service Work: The surgeon documents the operative procedure and develops the postoperative orders. Counsel the immediate family about the conduct of surgery, the expected care and outcomes. The first day postoperatively is typically in the ICU - managing the fluid shifts, cardiopulmonary and renal status of the patient. During the remaining seven hospital days, twice daily visits evaluate and manage the postanesthetic cardiopulmonary and renal status, wound drainage, pain management and the new stoma. Four outpatient visits for assessment of wound, evidence of infection, pain management and stoma care. All the visits include reconsideration for the pathologic staging and the implications for further adjuvant or palliative chemotherapy or radiation therapy.

CPT Code: 4511X**SURVEY DATA:**Specialty: American Society of Colon and Rectal SurgeonsSample Size: 80 Response Rate (%): 23.78% Median RVW: 23.5025th Percentile RVW: 23 75th Percentile RVW: 24.85 Low: 22.00 High: 26.25Median Pre-Service Time: 80 Median Intra-Service Time: 22525th Percentile Intra-Svc Time: 185 75th Percentile Intra-Svc Time: 240 Low: 170 High: 240

Median Post-Service Time:	<u>Total Time</u>	<u># of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>20</u>	<u>1</u>
Other Hospital:	<u>105</u>	<u>8</u>
Office:	<u>60</u>	<u>4</u>

KEY REFERENCE SERVICE(S):

<u>CPT CODE</u>	<u>[N]</u>	<u>CPT DESCRIPTOR</u>	<u>PRE (MIN)</u>	<u>INTRA (MIN)</u>	<u>POST (MIN)</u>	<u>RVW</u>	<u>M.E.</u>	<u>T.S.</u>	<u>P.S.</u>
4511X	19	Proctectomy with J-Pouch	80	225	225	24.69	5	5	4
44145	25	Low Anterior Resection	60	180	145	21.29	4	4	4
44153	18	Tot Colectomy; Ileal Pouch; Ileostomy	82.5	240	242.5	24.69	5	5	4.5

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Reference 44145 (21.29) represents a major component of the surveyed code (4511X). The preservice time is more extensive with 4511X because of the need for ileostomy counselling, marking the ileostomy site, and reviewing intraoperative decisions with the patient. 4511X also involves the work of creating a colonic J-Pouch. Finally, 4511X requires a diverting ileostomy in the majority of patients.

Code 44153 is extremely similar. The preservice and postservice work are so similar it is not worth drawing distinctions. The intraoperative service differs in that 44153 requires resection of the entire colon and creation of an ileal J-Pouch. The additional work of excising the entire colon in 44153 minimally exceeds the work in preserving the left colon, and mobilizing the transverse colon, splenic flexure and descending colon. Creating the ileal pouch and the colonic pouch are similar with subtle differences in preserving the blood supply and attaining adequate vascular length of the pouch mesentery to allow it to reach the anal canal. Therefore the ASCRS committee recommends the survey median which is minimally reduced from 44153.

ADDITIONAL RATIONALE

FREQUENCY INFORMATION

How was this service previously reported? Reported as two separate services

How often do physicians in your specialty perform this service? Commonly ☒ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1500

Is this service performed by many physicians across the United States? ☐ Yes ☒ No

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
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Laparoscopy with Intestinal Resection - Tab 19

A new CPT code 56348 was established to report an intestinal resection with anastomosis performed via laparoscopy. The work involved in 56348 is a really a combination of procedures that can be performed as one procedure through the laparoscope. The majority of the patients that would be receiving this procedure are suffering from the effects colorectal neoplasms, diverticular disease, and localized inflammatory bowel disease. During this procedure the diseased segment of the bowel is mobilized and the mesenteric transection, bowel transection, and anastomosis are performed. These procedures can be performed intracorporeally or extracorporeally, depending on conditions and the experience of the surgeon. Intestinal laparoscopic surgery is considered extremely difficult and less safe than the open procedure therefore, surgeons prefer to perform these cases as open procedures. However, when given the option patients prefer to have surgical procedures performed laparoscopically.

In the absence of a specific code, this surgery was most frequently reported as CPT code 44145 *Colectomy, partial; with coloproctostomy (low pelvic anastomosis)* (work RVU = 21.29). The specialty society noted that although the intra-service work of 56348 is of much greater intensity than similar open procedures, the post-operative care involves the same amount of work and the pre-operative care involves less work. The RUC accepted the specialty society recommendation of 20.00 RVUs for this procedure which is slightly less than the survey median.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•56348	O1	Laparoscopy, surgical; intestinal resection, with anastomosis (intra or extracorporeal)	090	20.00

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 563XX Tracking Number: O 1 Global Period: 090 Recommended RVW: 20.00

CPT Descriptor: Laparoscopy, surgical; intestinal resection, with anastomosis, (intra or extracorporeal).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: : A 23 yr old female with Crohn's disease has a sever sigmoid stenosis. Failing medical treatment, the operation includes laparoscopic assessmant of the intestinal tract for active Crohn's disease. Mobilize the sigmoid colon through four laparoscopic ports. The mesenteric and intestinal resection is accomplished intra/extracorporeally. Deliver the resected specimen through a suprapubic incision. Restore intestinal continuity with an end to end anastomosis using a transanal stapling device. The incision and port sites are closed. Postoperative care manages the associated ileus, immunosuppressive medications and wound care. Outpatient followup includes assessment for anastomotic complications.

Description of Pre-Service Work: Perform and review a complete history, physical and preoperative lab, X-ray and ECG profile. Counsel the patient and family about the operation. After induction of anesthesia, place the patient in the lithotomy position, protect and pad the extremities from injury with sequential compression stockings. Place an foley catheter in the bladder. Place a rectal catheter into the anus and irrigate the rectum with 3 liters, until clear. Position the laparoscopic equipment - CO2, video equipment, and monitors. Prepare the surgical site with antibiotic scrub. Surgical scrub, gown, prep and drape patient.

Description of Intra-Service Work: Under general anesthesia, surgical laparoscopy is performed. A supraumbilical incision is made, and the peritoneum is grasped with sutures on the fascia. The peritoneum is opened under direct vision. A Hassan blunt trocar is inserted. Gas flow is initiated to distend the abdomen, and the laparoscope is introduced. Gas flow and intra-abdominal pressure are carefully monitored so as ot to impair ventilation or venous return. The viscera are inspected. Three additional 10mm trocars are placed to expose, mobilize, and resect the pathologic segment of intestine (in this vignette - sigmoid). The mesenteric vessels are identified, double clamped and ligated through the laparoscope. The specimen is delivered to the abdominal wall in the lower abdomen. A separate incision is placed in the abdomen to deliver the specimen from the wound. An extracorporeal anastomosis is performed through the incision. Intracorporeal anastomoses are performed through the laprascope - as in this vignette. A trans-anal circular stapling device is used to perform the anastomosis. Meticulous hemostasis is ontained and the trocar are removed. The trocar sites are individually closed as is the lower abdominal incision.

Description of Post-Service Work: The surgeon documents the operative procedure and dèvelops the postoperative orders. Counsel the immediate family about the conduct of surgery, the expected care and outcomes. During the remaining seven hospital days, twice daily visits evaluate and manage the postanesthetic cardiopulmonary and renal status, wound drainage, pain management and the intestinal function. Three outpatient visits for assessment of wound, evidence of infection, and pain management.

SURVEY DATA:

Specialty: American Society of Colon and Rectal Surgeons

Sample Size: 80 Response Rate (%): (36.25% Median RVW: 21.00

25th Percentile RVW: 20.00 75th Percentile RVW: 23.00 Low: 13.10 High: 26.00

Median Pre-Service Time: 75 Median Intra-Service Time: 200
25th Percentile Intra-Svc Time: 150 75th Percentile Intra-Svc Time: 240 Low: 75 High: 270

CPT Code: 563XX

Median Post-Service Time:	<u>Total Time</u>	<u># of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u> </u>	<u> </u>
Other Hospital:	<u>70.00</u>	<u>5.0</u>
Office:	<u>45.00</u>	<u>3.0</u>

KEY REFERENCE SERVICE(S):

CPT CODE	[N]	CPT DESCRIPTOR	PRE (MIN)	INTRA (MIN)	POST (MIN)	1997 RVW	M.E.	T.S.	P.S.
563XX	29	Lap Intestinal Resection	75	200	145	20.00	4	5	4
44145	20	Low Anterior Resection	60	165	160	21.29	4	4	4
44150	13	Tot. Colectomy with ileostomy	80	170	185	19.04	4	4	4

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Reference 44145 (21.29) is similar to the surveyed code in pre time and work. The postservice differs in that these patients have a shorter length of stay, but have increased intraservice technical skill. The intraservice differences detail the increased work of laparoscopic assisted intestinal resection. This code - 563XX - represents large and small bowel resection. This is a mixed bag. The large bowel segmental resections and inflammatory small bowel resections are difficult resections with increased intensity. The limited small bowel resections are rare - and do not represent the typical case. 44150 appears comparable in pre and post service time; but with less intraservice time and technical skill compared to 563XX.

ADDITIONAL RATIONALE

Comparing 563XX to open procedures requires comparison to 44145 (21.29); Small bowel resection - 44120 (13.15); and a segmental colectomy - 44140 (16.97). The ASCRS committee reviewed these three procedures and feels that the increased technical skill and intraservice time suggest that the work is greater than 44150, but less than 44145. The committee recommends the 25% from the survey to reflect the midground in attempting to represent the spectrum of procedures covered by this code.

FREQUENCY INFORMATION

How was this service previously reported? Reported as 44145

How often do physicians in your specialty perform this service? X Commonly X Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 20,000

Is this service performed by many physicians across the United States? Yes X No
General Surgeons and Colorectal surgeons

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
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Closure of Rectovaginal - Tab 20

A new CPT code 57308 was established to report the work involved in closure of a rectovaginal fistula. This type of fistula most often occurs in women as a result of a normal vaginal delivery. In many instances a vaginal repair described by CPT code 57300 is attempted soon after delivery but failed, resulting in recurrence of the fistula and loss of sphincter function. The work described by 57308 is a complicated procedure that involves repair of the rectal mucosal defect, reapproximation of the sphincter muscle, and reconstruction of the perineal body. In the absence of a separate CPT code this service was reported as a combination of CPT codes 57300 *Closure of rectovaginal fistula; vaginal or transanal approach* (work RVU = 6.81) and 56810 *Perineoplasty, repair of perineum, nonobstetrical (separate procedure)* (work RVU = 3.97), or CPT codes 57300 *Closure of rectovaginal fistula; vaginal or transanal approach* (work RVU = 6.81) and 46750 *Sphincteroplasty, anal, for incontinence or prolapse; adult* (work RVU = 7.35). The new code more adequately describes these services in combination. The RUC accepted the specialty society recommendation of 9.31 RVUs for CPT code 57308 which is lower than the survey median of 11.00 RVUs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•57308	N1	Closure of rectovaginal fistula; transperineal approach, with perineal body reconstruction, with or without levator plication	090	9.31

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 5730X Tracking Number: N 1 Global Period: 090 Recommended RVW: 9.31

CPT Descriptor: Closure of rectovaginal fistula; transperineal approach, with perineal body reconstruction with or without levator plication..

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: : A 34 y/o female developed a rectovaginal fistula following childbirth. A prior vaginal repair attempt failed. A transperineal repair included preoperative mechanical and oral antibiotic bowel preparation. A perineal semicircular incision exposed the transperineal fistula. Repair the rectal mucosal defect and perform an external anal sphincteroplasty using an overlapping technique. Reconstruct the perineal body. Apply intestinal confinement protocol during the hospital stay. Outpatient visits include repair assessment, continence evaluation and management of pruritus or wound complications.

Description of Pre-Service Work: Perform and review a complete history, physical and preoperative lab X-ray and ECG profile. Counsel the patient and family about the operation and intraoperative decisions. After induction of anesthesia, place the patient in prone jack-knife position, protect and pad the extremities from injury. Prepare the surgical site with antibiotic scrub. Surgical scrub, gown, prep and drape patient.

Description of Intra-Service Work: Place a semicircular incision in the anterior perineum exposing the external anal sphincter. Place a probe in the fistula to identify the tract. Separate the tract from the associated sphincter with sharp dissection. Excise the vaginal and rectal mucosa involved in the fistula. Identify the underlying sphincter and perform an overlapping sphincter repair. Cover the sphincter with soft tissue in the rectovaginal septum. Suture the vaginal mucosa. Perform a perineoplasty for closure of the original perineal incision with a Y-plasty (some surgeons elect an X-Z plasty).

Description of Post-Service Work: The surgeon documents the operative procedure and develops the postoperative orders. Counsel the immediate family about the conduct of surgery, the expected care and outcomes. Three days of hospitalization with twice daily visits evaluating, assessing and managing the postanesthetic cardiopulmonary and renal status, wound drainage, pain management and bowel confinement protocol.. Three outpatient visits for assessment of wound, evidence of infection, pain management and continence evaluation - by history and physical examination. Assure that the fistula tract is obliterated.

SURVEY DATA:

Specialty: American Society of Colon and Rectal Surgeons

Sample Size: 80 Response Rate (%): 42.5% Median RVW: 11.00

25th Percentile RVW: 9.46 75th Percentile RVW: 13.00 Low: 6.15 High: 22

Median Pre-Service Time: 60 Median Intra-Service Time: 90

25th Percentile Intra-Svc Time: 71.25 75th Percentile Intra-Svc Time: 120 Low: 60 High: 180

CPT Code: 5730X

Median Post-Service Time: Total Time # of Visits

Day of Procedure: 30

ICU:

Other Hospital: 60 3

Office: 60 3.5

KEY REFERENCE SERVICE(S):

<u>CPT CODE</u>	<u>[N]</u>	<u>CPT DESCRIPTOR</u>	<u>PRE (MIN)</u>	<u>INTR A (MIN)</u>	<u>POST (MIN)</u>	<u>RVW</u>	<u>M.E.</u>	<u>T.S.</u>	<u>P.S.</u>
5730X	34	Closure Rectovag Fistula	60	90	150	9.31	4.0	4.0	4.0
45130	18	Perineal Proctosigmoidectomy with anastomosis	60	120	145	13.03	3.5	4.0	4.0
45170	16	Transanal Excision of Rectal Tumor	60	67.5	90	9.4	4.0	3.5	3.0

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The key reference services represent complex perineal operations and thus are similar to the complex nature of a transperineal operation to resolve a rectovaginal fistula. The preoperative work is similar in time for both reference services. The perineal proctosigmoidectomy (45130) involves more intraoperative work and stress. Removing 20-30cm of rectosigmoid transanally while controlling the mesenteric vessels and avoiding a traction injury to the spleen is more involved than excision of a rectovaginal fistula. Excision of a transanal rectal tumor closely approximates the pre, intra, and postoperative work of treating a rectovaginal fistula.

ADDITIONAL RATIONALE

The component operations of a transperineal treatment for rectovaginal fistulas include -

1. 46280 Excision of complex fistula RVw = 5.63
2. 46750 Sphincteroplasty RVw = 7.35

The primary service involves the work for excision of a complex fistula; thus, using the 46280 code as the primary service and 46750 as the secondary service -

$$[(\text{Code } 46280 = 5.63) + (\text{Code } 46750 / 2 = 7.35 / 2)]$$

$$5.63 \quad + \quad 3.68 = \quad 9.31$$

FREQUENCY INFORMATION

How was this service previously reported? Reported as two to three separate services

How often do physicians in your specialty perform this service? Commonly Sometimes X Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1000

Is this service performed by many physicians across the United States? Yes X No

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**CPT Code: 5730X Tracking Number: Global Period: 090 Recommended RVW: 9.3

CPT Descriptor: Closure of rectovaginal fistula; transperineal approach, with perineal body reconstruction, with or without levator plication

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 34 year old female developed a rectovaginal fistula following childbirth. A prior vaginal repair attempt failed. A transperineal repair included preoperative mechanical and oral antibiotic bowel preparation. A perineal semicircular incision exposed the transperineal fistula. Repair the rectal mucosal defect and perform an external anal sphincteroplasty using an overlapping technique. Reconstruct the perineal body. Apply intestinal confinement protocol during the hospital stay. Outpatient visits include repair assessment, continence evaluation and management of pruritis or wound complications.

Description of Pre-Service Work: Perform and review a complete history, physical, and preoperative lab, x-ray, and ECG profile. Counsel the patient and family about the operation and intraoperative decisions. After introduction of anesthesia, place the patient in prone jack-knife position, protect and pad the extremities from injury. Prepare the surgical site with antibiotic scrub. Surgical scrub, gown, prep, and drape patient.

Description of Intra-Service Work: Place a semicircular incision in the anterior perineum exposing the external anal sphincter. Place a probe in the fistula to identify the tract. Separate the tract from the associated sphincter with sharp dissection. Excise the vaginal and rectal mucosa involved in the fistula. Identify the underlying sphincter and perform an overlapping sphincter repair. Cover the sphincter with soft tissue in the rectovaginal septum. Suture the vaginal mucosa. Perform a perineoplasty for closure of the original perineal incision with a Y-plasty.

Description of Post-Service Work: The surgeon documents the operative procedure and develops the postoperative orders. Counsels the family about the conduct of the surgery, the expected care and outcomes. Three days of hospitalization with twice daily visits evaluating, assessing, and managing the postanesthetic cardiopulmonary and renal status, wound drainage, pain management and bowel confinement protocol. Three outpatient visits for assessment of wound, evidence of infection, pain management and continence evaluation by history and examination. Assure that the fistula tract is obliterated.

SURVEY DATA:Specialty: American College of Obstetricians and GynecologistsSample Size: 44 Response Rate (%): 22 (50%) Median RVW: 8.525th Percentile RVW: 7.71 75th Percentile RVW: 10.5 Low: 6.81 High: 10.5Median Pre-Service Time: 60 Median Intra-Service Time: 9025th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 101 Low: 45 High: 150Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 30ICU: Other Hospital: 42.5 3Office: 37.5 3

CPT Code: 5760X**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	57300	Closure of rectovaginal fistula; vaginal or transanal approach	6.81
2)	56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)	3.97
3)	57305	Closure of rectovaginal fistula; abdominal approach	12.75
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 5730X requires 50 percent more intraservice time than CPT 57300. Pre- and post-service times are similar for 5730X and 57300. The new procedure (5730X) requires less pre-, intra-, and post-service time than 57305. Intensity levels are similar. Total physician work for CPT 5730X is about midway between 57300 and 57305, so the mean estimated RVW of 9.3 seemed more appropriate than the median of 8.5.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
5730X	60	90	30	4	4	4
57300	60	60	30	4	4	3
57305	75	105	42	4	4	4

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? Reported as two to three separate services

How often do physicians in your specialty perform this service? Commonly ☒ Sometimes ☐ Rarely ☐

Estimate the number of times this service might be provided nationally in a one-year period? 1,000

Is this service performed by many physicians across the United States? Yes ☒ No ☐

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
FEBRUARY AND APRIL 1997

Laparoscopic Surgery - Tab 21 and Tab 27

A series of new codes have been established which recognize the advances in laparoscopic surgery.

The work described by 56310 is a procedure that involves enterolysis performed laparoscopically. Enterolysis performed via the laparoscope is more complicated than the open procedure because the surgeon often experiences difficulty feeling the loops of the bowel making it hard to lyse adhesions without damaging the bowel. Adhesions often occur in patients who have had previous surgery which increases the difficulty of this procedure. This procedure was previously reported as CPT code 44005 *Enterolysis (freeing of intestinal adhesion) (separate procedure)* (work RVU= 12.52). The RUC accepted a recommendation of 13.50 RVUs for this procedure which represent the specialty society survey median.

The work described by 56346 involves gastrostomy performed laparoscopically. This procedure represents a new approach to gastrostomy and has a very low frequency. The procedure which is done for alimentation purposes involves suturing the tube into position and then suturing the stomach to the abdominal wall. Unlike the open procedure, the surgeon must visually identify structures through the laparoscope that should be cut or preserved which increases the difficulty of the procedure. Due to the suturing that is an integral part of this procedure more work is involved in the control of bleeding. This procedure was previously reported as CPT code 43840 *Gastrorrhaphy, suture for perforated duodenal gastric ulcer, wound or injury* which at the time the new code was surveyed had a work RVU of 4.84. The RUC recommended an RVU of 7.18 which is slightly lower than the specialty survey median but reflects the fact that the reference code RVU was increased for the 1997 Medicare Fee Schedule due to the Five-Year Review.

The work described by 56318 involves an orchiectomy performed laparoscopically. This procedure is typically performed on young males to correct the condition of undescended testicles. In a small percentage of these undescended testicle patients, the testicle is not palpable in the inguinal canal therefore, the operating surgeon often does not the exact location of the testicle which adds significant risk to this surgical procedure. There is a somewhat greater success associated with treating the nonpalpable cases laparoscopically as opposed to the open procedure described by code 54560 (work RVU= 10.46). The RUC recommended an RVU of 10.63 for this procedure which represents the specialty society survey median.

The work described by 56349 involves esophagogastric fundoplasty performed laparoscopically. This procedure is considered very difficult and performed by only the most experienced laparoscopic surgeons. Which is reflected in the specialty society survey data which shows that there is no difference in the amount of time based on the number of procedures that the surgeon has performed. This procedure is typically performed on patients to relieve the symptoms that are associated with esophagogastric reflux disease. The purpose of the procedure is to increase the angle at which the esophagus enters the stomach. The difficulty of the surgery is due in part to the fact that the surgeon cannot rely on tactile information during the procedure. Additionally, there is more work involved in the control of bleeding. This procedure was previously reported as CPT code 43324 *Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures)* (work RVU= 15.18). The new procedure is considered more difficult than the laparoscopic cholecystectomy described by code 56342 (work RVU= 13.46), because the surgeon must dissect the short gastric vessels. The RUC recommended an RVU of 17.75 for this procedure which represents the specialty society survey median.

One specialty society did not survey codes 56347 (P4) or 56345 (P7) and will not present recommendations in time for the 1998 MFS. The RUC will consider recommendations at the September meeting and will submit comments on the HCFA assigned interim values published in the 1998 MFS Final Rule.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
56304	P1	<i>Laparoscopy, surgical, with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)</i>	010	10.00 (See recommendations for Laparoscopy and Hysteroscopy, April Tab 10)
•56310	P2	enterolysis (freeing of intestinal adhesion) (separate procedure)	090	13.50
•56346	P3	gastrostomy, temporary (tube or rubber or plastic) (separate procedure)	090	7.18
•56347	P4	jejunostomy (eg, for decompression or feeding)	090	No Recommendation
•56318	P5	orchiectomy	090	10.63
•56349	P6	esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill, Toupet procedures)	090	17.75
•56345	P7	splenectomy	090	No Recommendation

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

44200

X
AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 563X1 (P2)

Global Period: 090

Recommended RVW: 13.50

CPT Descriptor: Laparoscopy, surgical; enterolysis (freeing of intestinal adhesion) (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:**Vignette Used in Survey:**

A 55-year-old female, who has had a previous hysterectomy and bilateral salpingoophorectomy, presents with nausea and vomiting. Abdominal radiographs reveal multiple air fluid levels consistent with small bowel obstruction. Conservative management with nasogastric tube decompression is begun. Signs and symptoms of small bowel obstruction continue and are confirmed by repeat abdominal radiographs. She is taken to the operating room where laparoscopic lysis of adhesions is performed uneventfully. She is observed closely in the hospital for four days until oral feedings are well tolerated, then she is discharged home with instructions on enteral feeding.

Description of Pre-Service Work: Pre-service work begins after the decision to operate is made and until the time of the procedure. This activity includes reviewing the previous work-up, including consulting with the referring physician, if necessary, and other health care professionals, such as the anesthesiologist; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include scheduling the operation, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: A supra-umbilical incision is made, and the peritoneum is grasped with sutures on the fascia. The peritoneum is opened carefully under direct vision, taking care not to puncture the distended loops of bowel, which are immediately underneath the abdominal wall. A Hasson blunt trocar is inserted, avoiding the previous incision. The laparoscope is introduced, and gas flow is instituted to insufflate the abdomen. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation and venous return. The viscera are inspected, and multiple dilated small bowel loops are encountered. Three additional trocars are placed under direct vision depending on the initial impression of the site of obstruction. The location of the adhesion is noted; and the site of obstruction, with dilated loops proximal and collapsed small bowel loops distal, is identified. Adhesions are coagulated and lysed, and the obstructing adhesion is carefully divided under direct vision avoiding puncturing the distended compromised bowel. Serosal defects are closed using multiple endocavitary sutures with endocavitary knot-tying techniques. Meticulous hemostasis is maintained, and the peritoneal cavity is irrigated. The trocars are removed under direct vision to assure no abdominal wall vascular injury or hemorrhage. The abdominal gas is evacuated, and the trocar sites are closed with multiple sutures.

Description of Post-Service Work: Post-service work begins in the operating room after skin closure with the application of sterile dressings. Post-service work also includes monitoring the patient's stability in the recovery room; writing orders and dictating an operative summary; communicating with the family and other health care professionals (including written and oral reports and orders); ICU care and ventilatory management, if necessary; ordering and reviewing postoperative radiographs and laboratory studies; careful attention to fluid-volume and electrolyte status; monitoring and care of the incision; monitoring, maintaining, and removing all tubes and drains; antibiotic and pain medication management; and all other hospital visits and services performed by the surgeon. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge visits for this procedure for 90 days after the day of operation are considered part of the post-service work, including removal of sutures;

ordering and evaluating periodic imaging and laboratory studies, if needed; obtaining and reviewing all final surgical histopathology results; further coordination of care with the referring physician; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American College of Surgeons

Survey n:	88				POST (details)							
		PRE	INTRA	POST								
Response:	43				Day 1	ICU		Hosp. - Other		Office		
Rate %:		RV				#	total	#	total	#	total	
49%		W	min	min	min	visits	min	visits	min	visits	min	
	low	12.50		60								
	25th %	13.00		93								
	MED	13.50	100	120	150*	30	0	0	5	60	2	30
	75th %	15.00		150								
	high	25.04		210								
* Includes four hospital visits at 15 minutes each and one visit for discharge day management at 30 minutes.												

Comparative Data for Surveyed Service and Key Reference Service(s):

CPT Code	1996 RVW	Pre (min)	Intra (min)	Post (min)	ME & J** mean	TS & PE** mean	PS* mean
P2	13.50	100	120	150	3.72	4.10	3.77
44005	12.52	90	90	135	2.87	2.89	2.68

**ME & J: mental effort and judgment. TS & PE: technical skill and physical effort. PS: psychological stress.

KEY REFERENCE SERVICE(S):

CPT	Descriptor	96rvw	97rvw	glob
44005	Enterolysis (freeing of intestinal adhesion) (separate procedure)	12.52	no chg	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The survey data for the pre- and intra-service time for P2 are greater than the key reference service 44005 and support an RVW for P2 that is greater than 44005. In addition, the survey data for mental effort and judgment, technical skill and physical effort, and psychological stress, are increased in each category for P2, when compared to 44005.

Adhesions often occur in patients who have had previous operations. The increased intensity in the laparoscopic approach versus the open approach, as demonstrated by the survey data, can be explained by the fact that the difficulty of a laparoscopic procedure is increased when there are complicating factors, such as obesity or prior operations. For example, it is more difficult to determine where, precisely, to place the trocars in patients with previous operations so as not to puncture the bowel. Lysis of adhesions can be a tedious and difficult operation. In part, the complexity of the procedure is determined by patients' varying responses to previous operations.

Additionally, more effort and work are needed to perform a laparoscopic lysis of adhesions, as opposed to an open lysis of adhesions, in order to properly visually identify structures that should be cut or preserved. With an open procedure, the surgeon has both the advantage of tactile information, as well as the ability to view the operative field from more than one restricted view. Similarly, the work needed to take care of bleeding, suturing of structures, and coaptation of bowel is increased, due to the more complex and time consuming methods required for laparoscopic suturing.

ADDITIONAL RATIONALE (eg, if recommended RVUs are based on an alternative method instead of the survey results): N/A

FREQUENCY INFORMATION

- How was this service previously reported? **CPT 44005**
- How often do physicians in your specialty perform this service? **Commonly** **Sometimes** **Rarely**
- Estimate** the number of times this service might be provided nationally in a one-year period?
1995 Medicare allowed frequency for CPT 44005 was 28,960.
12% of these will now be reported using 563X1 (P2) [12% of 28,960 = **3,475**]
- Is this service performed by many physicians across the United States? **Yes** **No**

563446 - renumbered
to 43653

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 563X2 (P3)

Global Period: 090

Recommended RVW: 7.40

CPT Descriptor: Laparoscopy, surgical; gastrostomy, temporary (tube or rubber or plastic) (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 65-year-old male presented with an obstructing carcinoma of the esophagus and inability to eat orally. Attempts to relieve the obstruction by flexible endoscopy, dilatation, and laser therapy are unsuccessful. The patient is malnourished and needs enteral nutritional support prior to future definitive cancer therapy, which may include chemotherapy, radiation therapy, and/or an operation. The decision is made to perform a laparoscopic feeding gastrostomy. He is discharged two days postoperatively with instructions for wound care and gastrostomy feeding techniques.

Description of Pre-Service Work: Pre-service work begins after the decision to operate is made and until the time of the procedure. This activity includes obtaining and reviewing the previous work-up, with special attention to cardiopulmonary, gastrointestinal, nutritional and hematologic status; reviewing previous CT scans and ultrasounds, pathology and laboratory studies; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: Under general anesthesia, surgical laparoscopy is performed. An infra-umbilical incision is made, and the peritoneum is grasped with sutures on the fascia. The peritoneum is opened carefully under direct vision, taking care not to puncture the distended loops of bowel, which are immediately underneath the abdominal wall. A Hasson blunt trocar is inserted. Gas flow is initiated to distend the abdomen, and the laparoscope is introduced. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation and venous return. The viscera are inspected. Two additional trocars are placed under direct vision. An atraumatic grasper through one port grasps the midbody of the stomach and elevates it from the pancreas. A skin incision is made in the left upper quadrant after pushing down on the skin and selecting the site for the gastrostomy. Beneath the left costal margin, a 7-cm, 18-gauge needle is inserted through the skin and into the stomach under direct vision. Two or three Cope suture anchors are placed by pushing the T-bar anchor out of the needle with a wire. The 18-gauge needle is replaced into the stomach between the anchors, and a J-wire is threaded via the needle into the stomach. Sequential 12- and 14-French dilators are gently twisted over the guide wire prior to passing a 17-French silastic balloon catheter through the peelaway sheath into the stomach. The catheter balloon is inflated with 5-10 ml of water. The peelaway sheath is removed, and the catheter is secured in place after securing the stomach up to the abdominal wall. Meticulous hemostasis is maintained, and the peritoneal cavity is irrigated. The trocars are removed under direct vision to assure no abdominal wall vascular injury or hemorrhage. The abdominal gas is evacuated, and the trocar sites are closed with multiple sutures.

Description of Post-Service Work: Post-service work begins after skin closure in the operating room and includes the application of sterile dressings. Post-service work also includes monitoring the patient's stability in the recovery room; writing orders and dictating an operative summary; communicating with the family and other health care professionals (including written and oral reports and orders); ICU care and ventilator management, if necessary; ordering and reviewing postoperative radiographs and laboratory studies; monitoring and care of the incision; monitoring, maintaining, and removing all tubes and drains; obtaining a nutritional assessment and initiating early postoperative enteral feedings; antibiotic and pain medication management; and all other hospital visits and services performed by the surgeon. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge visits for this procedure for 90 days after the day of operation are considered part of the post-service work including removal of sutures; ordering and evaluating periodic imaging and laboratory reports, if needed; obtaining and reviewing all final surgical histopathology results; further coordination of care with the referring physician; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American College of Surgeons

Survey n: 88

Response: 42

Rate: %:
48%

	RVW	PRE	INTRA	POST	POST (details)						
		total min	total min	total min	Day 1 total min	ICU		Hosp. - Other		Office	
						# visits	total min	# visits	total min	# visits	total min
low	3.20		30								
25th %	5.00		60								
MED	5.50	60	70	105	30	0	0	2	15	2	30
75th %	7.63		90								
high	13.15		120								
* Includes one hospital visit at 15 minutes and one visit for discharge day management at 30 minutes.											

Comparative Data for Surveyed Service and Key Reference Service(s):

CPT Code	1997 RVW	Pre (min)	Intra (min)	Post (min)	ME & J** mean	TS & PE** mean	PS** mean
P3	7.40	60	70	105	2.86	3.19	2.79
43830	6.52	60	45	100	2.29	2.16	2.11

**ME & J: mental effort and judgment. TS & PE: technical skill and physical effort. PS: psychological stress.

KEY REFERENCE SERVICE(S):

Resp	CPT	Descriptor	96rvw	97rvw	glob
38	43830	Gastrostomy, temporary (tube, rubber or plastic) (separate procedure);	4.84	6.52	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The survey data for the pre- and intra-service time for P3 are greater than the key reference service 43830 and support an RVW for P3 that is greater than 43830. In addition, the survey data for mental effort and judgment, technical skill and physical effort, and psychological stress, are increased in each category for P3, when compared to 43830.

Some of the patients who require this procedure have sustained neurological injuries, esophageal obstructions, gastroesophageal obstructions, or chronic debilitation and require long-term nutritional support. Many of these patients are not candidates for percutaneous endoscopic gastrostomy or long-term nasogastric tube feeding. According to Medicare data, 92.2 percent of patients requiring this service are age 70 and older. Pediatric patients with repeated aspiration pneumonias secondary to gastroesophageal reflux also may require this service.

This procedure involves suturing the tube into position and then suturing the stomach to the abdominal wall. This action assures that, if the tube is dislodged, there is no spillage of the gastric contents into the peritoneal cavity, which could result in peritonitis. This is a technically demanding procedure, especially when it is done laparoscopically.

Futhermore, more effort and work are needed to perform a laparoscopic gastrostomy as opposed to an open procedure in order to properly visually identify structures that should be cut or preserved. With an open procedure, the surgeon has both the advantage of tactile information, as well as the ability to view the operative field from more than one restricted view. Similarly, the work needed to take care of bleeding and suturing of structures is increased due to the more complex and time consuming methods required for laparoscopic suturing.

ADDITIONAL RATIONALE (eg, if recommended RVUs are based on an alternative method instead of the survey results):

When the survey for this code was conducted, one of the services that was included on the reference list was 43830, which, at that time, had a value of 4.84. This code was revalued as part of the five-year review of the Medicare fee schedule, and the final value of 6.52 was published by HCFA in the November 22, 1996 issue of the *Federal Register*. The value that is recommended for P3 has been adjusted to reflect the increase in code 43830, which is the key reference service for this code.

$$6.52/4.84 = xx$$

$$xx(5.50) = 7.40$$

FREQUENCY INFORMATION

1. How was this service previously reported? CPT 43830
2. How often do physicians in your specialty perform this service? ~~Commonly~~ Sometimes Rarely
3. Estimate the number of times this service might be provided nationally in a one-year period?

1995 Medicare allowed frequency for CPT 43830 was 20,439
 90% were performed for alimentation purposes [90% of 20,439 = 18,395]
 50% of these will now be reported using 563X2 (P3) [50% of 18,395 = 9,198]

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

CPT Code: **CPT 563X4** Tracking Code: **P5** Global Period: **090** Recommended RVW: **10.63**

CPT Descriptor: Laparoscopy, surgical; orchiectomy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 10-year old male has had a non-palpable right testicle since birth. CT scan of the abdomen suggests a high intra-abdominal right testicle. After discussion with the patient's parents, laparoscopic exploration of the abdomen with laparoscopic orchiectomy, if indicated, is elected.

Description of Pre-Service Work: Includes services provided from the day before the surgery until the time of the procedure and may include: (1) obtaining and reviewing hospital admission laboratory studies and urologic x-rays before the procedure; (2) communicating with other health care professionals (e.g., family physician, anesthesiologist); (3) communicating with the patient to explain operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (e.g., placing of central arterial and venous lines, administering general, spinal and/or epidural anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery and any other non "skin-to-skin" work in the operating room. Does not include: Consultation or evaluation at which the decision to provide the procedure was made.

Description of Intra-Service Work: Under general anesthesia the patient appropriately positioned for laparoscopy, operating trocars and ports are introduced after creation of a pneumoperitoneum. Diagnostic laparoscopy is carried out and a small testicle with a slightly detached epididymis is identified. It is elected to remove the testicle laparoscopically. The operative field and port sites are checked for hemostasis and the wounds are closed with sutures. The patient is taken to the recovery room.

Description of Post-Service Work: Includes the following: (1) all post-operative care 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 room; (2) all post-operative hospital visits and discharge day management; (3) 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 evaluation of periodic laboratory reports and medication adjustment)

SURVEY DATA:

Specialty: American Urological Association

Sample Size: 38 Response Rate (%): (28/38) 73% Median RVW: 10.63

25th Percentile RVW: 9.81 75th Percentile RVW: 15.00 Low: 6.00 - High: 18.00

Median Pre-Service Time: 75 minutes Median Intra-Service Time: 90 minutes

25th Percentile Intra-Svc Time: 60 minutes 75th Percentile Intra-Svc Time: 120 minutes Low: 60 minutes
High: 240 minutes

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 60 minutes

ICU: 0 minutes 0 visits

Other Hospital: 12.5 minutes 1 visit

Office: 30 minutes 2 visits

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	50620	Ureterolithotomy; middle one-third of ureter	14.17
2)	54640	Orchiopexy, inguinal approach, with or without hernia repair	6.55

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
50620	60 minutes	90 minutes	30 minutes; 0 ICU; 3 45-min other hosp; 2.5 40-min other office	3	2.5	3
54640	55 minutes	60 minutes	20 minutes; 0 ICU; 0 other hosp; 1 20-min other office	2	3	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? CPT 54560

How often do physicians in your specialty perform this service? Commonly Sometimes XX Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1,530 - 3,060

Is this service performed by many physicians across the United States? Yes XX No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 563X5 (P6)

Global Period: 090

Recommended RVW: 17.75

CPT Descriptor: Laparoscopy, surgical; esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill, Toupet procedures)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 35-year-old male has been treated for six months with Prilosec® for severe symptoms of reflux esophagitis. He is evaluated by upper endoscopy, barium swallow radiographs, and manometric and pH studies of the esophagus. His symptoms persist, and he has laparoscopic antireflux surgery. He is discharged home on the third postoperative day.

Description of Pre-Service Work:

Pre-service work begins after the decision to operate is made, from the day before the operation until the time of the procedure. This activity includes obtaining and reviewing the previous work-up, with special attention to cardiopulmonary, gastrointestinal, and hematologic status; reviewing previous CT scans and ultrasounds, pathology and laboratory studies; consulting with the referring physician, if necessary, and other health care professionals; and communicating with the patient (and/or the patient's family) to explain the operative risks and benefits and to obtain informed consent. Other preoperative services include dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work: Under general anesthesia, surgical laparoscopy is performed. An supra-umbilical incision is made, and the peritoneum is grasped with sutures on the fascia. The peritoneum is opened carefully under direct vision. A Hasson blunt trocar is inserted. Gas flow is initiated to distend the abdomen, and the laparoscope is introduced. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation and venous return. The viscera are inspected. Four additional 10-mm trocars are placed, two along the left subcostal margin, one in the subxiphoid region, and one along the right subcostal margin in the midclavicular line. (For those cases in which the short gastric vessels are to be divided with a linear stapler-cutter, a 12-mm trocar is placed.) The left lobe of the liver is retracted to the right with an inflatable laparoscopic retractor that is introduced through the subxiphoid port. The stomach is retracted inferolaterally with a Babcock forceps inserted through the lateral left subcostal port to visualize the esophageal junction. A nonratcheted grasping forceps is introduced through the third port and laparoscopic scissors or hook electrocautery through the fourth port. Diathermy is used only for the division of the peritoneum. The peritoneum at the gastroesophageal junction is opened and the esophagus is identified. The esophagus can be safely mobilized primarily by blunt dissection using a palpation probe. During this dissection, the esophageal hiatus is exposed, and the right crus and posterior vagus are identified. In those patients in whom the upper pole of the spleen is very close to the gastroesophageal junction, the short gastric vessels are first taken down before completely mobilizing the esophagus, thus avoiding iatrogenic splenic injury. For the creation of the window posterior to the esophagus, a 30 degree laparoscope is used, which allows better visualization of this region. To facilitate division of the short gastric vessels, the stomach is retracted to the right by a Babcock forceps that is introduced through port 3. An inflatable atraumatic retractor that is inserted through port 5 is used to gently retract the gastrosplenic omentum to the left. A right-angle dissecting forceps is utilized through port 4 to isolate the short gastric vessels. These vessels are doubly clipped and divided. A right-angle clip applicator facilitates the ligation of the short gastric vessels. A Babcock forceps passed posterior to the esophagus is used to grasp the gastric fundus. The fundus is brought around the esophagus to form the wrap. Two or three stitches are used to close the esophageal hiatus by sewing the right and left crus of the diaphragm. A 4-5-cm fundoplication is completed with interrupted 2-0 sutures, taking bites of the stomach. To prevent slippage of the wrap, the upper part of the crus is incorporated in the first (upper) stitch, and a small bite of the gastroesophageal junction in the last stitch (lower). Meticulous hemostasis is maintained, and the peritoneal cavity is irrigated. The trocars are removed under direct vision to assure no abdominal wall vascular injury or hemorrhage. The abdominal gas is evacuated, and the trocar sites are closed with multiple sutures.

Description of Post-Service Work:

Post-service work begins after skin closure in the operating room and includes the application of sterile dressings. Post-service work also includes monitoring the patient's stability in the recovery room; writing orders; communicating with the family and other health care professionals (including written and oral reports and orders); and all hospital visits and services performed by the surgeon, including ICU care and ventilator management, as necessary; careful monitoring of cardiopulmonary status; ordering and reviewing postoperative radiographs and laboratory studies; monitoring and care of the incision; monitoring, maintaining, and removing all tubes and drains; and antibiotic and pain medication management. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, 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 sutures; ordering and evaluating periodic imaging and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA: Specialty(s): American College of Surgeons

Survey n:	88		PRE	INTRA	POST	POST (details)						
Response:	43						ICU		Hosp. - Other		Office	
Rate %: 49%		RVW	total min	total min	total min	Day 1 total min	# visits	total min	# visits	total min	# visits	total min
	low	14.00		90								
	25th %	16.10		130								
	MED	17.75	100	150	135*	30	0	0	3	30	3	45
	75th %	19.00		180								
	high	52.00		240								
* Includes two hospital visits at 15 minutes each and one visit for discharge day management at 30 minutes.												

Comparative Data for Surveyed Service and Key Reference Service(s):

CPT Code	1996 RVW	Pre (min)	Intra (min)	Post (min)	ME & J* mean	TS & PE* mean	PS* mean
P6	17.75	100	150	135	4.21	4.67	4.33
43324	15.18	83	120	148	3.59	3.33	3.21

*ME & J: mental effort and judgment. TS & PE: technical skill and physical effort. PS: psychological stress.

KEY REFERENCE SERVICE(S):

Resp	CPT	Descriptor	96rvw	97rvw	glob
40	43324	Esophagogastric fundoplasty (eg, Nissen, Belsey IV, Hill procedures)	15.18	no chg	090

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The survey data for the pre- and intra-service time for P6 are greater than the key reference service 43324 and support an RVW for P6 that is greater than 43324. In addition, the survey data for mental effort and judgment, technical skill and physical effort, and psychological stress, are increased in each category for P6, when compared to 43324.

Dissection of the short gastric vessels is more difficult to do laparoscopically than when it is done as an open procedure, as is dissection of the esophagus and the retroesophageal space. Similarly, preparing and sewing the crus of the diaphragm, as well as creating the wrap, are technically more difficult when done laparoscopically.

Futhermore, more effort and work are needed to perform a laparoscopic esophagogastric fundoplasty as opposed to an open procedure in order to properly visually identify structures that should be cut or preserved. With an open procedure, the surgeon has both the advantage of tactile information, as well as the ability to view the operative field from more than one restricted view. Similarly, the work needed to take care of bleeding and suturing of structures is increased due to the more complex and time consuming methods required for laparoscopic suturing.

ADDITIONAL RATIONALE (eg, if recommended RVUs are based on an alternative method instead of the survey results): N/A

FREQUENCY INFORMATION

- How was this service previously reported? CPT 43324
- How often do physicians in your specialty perform this service? Commonly Sometimes Rarely
- Estimate the number of times this service might be provided nationally in a one-year period?

This disease affects 10 percent of the adult population of the US. Of those with this disease, 90 percent will be treated medically. Ten percent will require surgical intervention, and of this number, 5 percent will be treated laparoscopically. However, the percent requiring surgical intervention is increasing.

1995 Medicare allowed frequency for CPT 43324 was 5,013

5% of these will now be reported using 563X5 (P6) [5% of 5,013 = 250]

4. Is this service performed by many physicians across the United States? Yes ~~No~~

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
FEBRUARY 1997

Lymphocele Drainage - Tab 22

The work described by the new code 49062 describes the open drainage of a lymphocele. Although this procedure does not represent new technology the new code will more adequately describe that services that are involved. The typical patient usually develops lymphoceles as a result of renal transplant surgery or retropubic prostatectomy. This procedure is equivalent in terms of work to CPT code 49060 *Drainage of peritoneal abscess* (work RVU= 10.55). Since the conditions that result in this type of surgery are uncommon, the procedure is performed on a relatively limited basis. Although this procedure achieves the same result as percutaneous abscess drainage, the patient undergoing the procedure described by 49062 has failed the percutaneous procedure. When a patient presents for surgery, the surgeon will determine based on their skill and experience whether or not the procedure should be performed as an open or laparoscopic procedure. The RUC recommended an RVU of 10.78 for this procedure which was based on a survey median from over 30 urologists.

A new code 56314 was added for laparoscopic lymphocele drainage. This work involved in this procedure is the same as the open lymphocele drainage and involves similar patients. This procedure is based on the experience of the surgeon not the availability of the technology. The RUC recommended an RVU of 8.93 which was based on a survey median from over 30 urologists.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•49062	CC1	Drainage of extraperitoneal lymphocele to peritoneal cavity, open	090	10.78
•56314	CC2	Laparoscopy, surgical; with drainage of lymphocele to peritoneal cavity	010	8.93

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
FEBRUARY 1997

Urethral Endoprosthesis - Tab 24

A new code 52282 was added to describe the use of endoprosthetic stents in the treatment of urethral stricture disease. The treatment of a urethral stricture involves a cystoscopy and the excision of the stricture using cold knife technique. Once the stricture is excised, a stent is placed over the stricture site. This a very difficult procedure due to the many complications that are associated with stent placement. The patient often experiences incontinence therefore, sometimes the stent is placed across the urogenic bladder to make the continent. Since the stent cannot be moved once it is placed, it is imperative the stent placement will not result in the patient becoming incontinent. The work involved in this procedure is similar to the reference services 52276 *Cystourethroscopy with direct vision urethrotomy* (work RVU= 5.00) and 52277 *Cystourethroscopy, with resection of external spinchter* (work RVU= 6.17). Based on the survey median of over 30 urologists, the RUC recommended an RVU of 6.40 for this procedure.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•52282	DD1	Cystourethroscopy, with insertion of urethral stent	000	6.40

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
FEBRUARY 1997

Kyphectomy - Tab 25

New CPT codes were added to describe Kyphectomy, a procedure to performed on spina bifida patients to allow correction and stabilization of the deformity, decreased skin problems, increased pulmonary function, and improved sitting balance. Fewer than 150 of these procedures are performed each year in the United States by fewer than 100 pediatric orthopaedic surgeons. The procedure has high mortality and morbidity rates.

The RUC recommends work relative values based on the survey results of more than 40 pediatric orthopaedic surgeons who perform this procedure. The majority of the survey respondents compared code 22818 *Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or two segments* to CPT code 63087 *Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s) lower thoracic or lumbar; single segment* (work rvu = 33.91). Both services require similar amounts of intra-service time (240 minutes) and intensity. The intra-service time of 63087 has been confirmed by the Harvard study (258 minutes), Five-Year Review data (265 minutes), and this survey (240 minutes). Associated arthrodesis, instrumentation, and bone grafting are not included in either of these services and are reported separately. The RUC recommends 30.00 for 22818.

The RUC recommends 34.50 for code 22819, *Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); 3 or more segments*, which is also based on the survey median. The 15% increase in the work value for an additional segment is comparable to the 16% increase established for the additional segments for the spine codes, which has been validated in both the RUC process and Harvard's Phase IV study.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•22818	AA1	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or two segments	090	30.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•22819	AA2	3 or more segments (To report arthrodesis, see 22800-22804 and use modifier - 51)	090	34.50

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

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

CPT Code: 228X1 Tracking Number: AA1 Global Period: 090 Recommended RVW: 30.00

CPT Descriptor:

Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements), single or two segments.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

An 8 year old thoracic level myelomeningocele patient with progressive congenital kyphotic deformity undergoes kyphectomy with resection of L1 and L2 involving a circumferential exposure via posterior approach. *(Note: Associated arthrodesis, instrumentation and bone grafting are not included in this code and are reported separately.)*

Description of Pre-Service Work:

In the 24 hours prior to surgery, the surgeon has reviewed the previously obtained preliminary laboratory data including urinalysis and possibly urine cultures. Because of the high incidence of associated urinary tract infections in spina bifida patients, appropriate urinary antibiotics is reviewed. Pre-operative x-rays and imaging studies are gathered and reviewed, as well as any preliminary associated studies such as pulmonary function tests. On the morning of surgery, all information is reviewed and the patient is re-examined paying particular attention to the condition of the skin in the area of the kyphotic deformity, as well as pulmonary function and the condition of the patient's urine. The surgeon checks on the availability of blood for the necessary transfusions. The family and patient are recounseled and the operative risks and benefits are reviewed once again. After dressing, the surgeon assists in positioning the patient after appropriate general anesthesia is available and appropriate intravenous and intra-arterial lines including urinary catheter have been placed. The surgeon often assists in placement of these lines. The surgeon positions the patient on the operating table paying particular attention to padding the iliac crests and chest, as well as the legs. It should be noted that in the patient without sensation, appropriate protection is necessary for this lengthy procedure. The physician reviews the available surgical instrumentation which has been previously selected, as well as the making sure that all supplies that are necessary are present and available in the operative suite. The physician supervises the prepping of the patient and drapes the patient to expose the area of the surgical procedure. In addition, the surgeon prepares for the radiographic imaging control that will be necessary during surgery.

Description of Intra-Service Work:

The mid-line incision is made through the length of the planned procedure. Because of the previously closed spina bifida over the area of the kyphotic deformity, it is not possible to make an incision to level of the spinous process as these remain open. The incision begins at the areas of intact spinous processes proximal to the spina bifida lesion. Careful dissection elevating the musculature and periosteum of spinous processes, facet joints and transverse processes is performed. This is continued distally at each level of exposure starting at least two levels proximal to the spina bifida defect. As the spina bifida defect is encountered, the exposure is lateral to the defect. The musculature is elevated from the displaced spinous processes on the right and left sides, facet joints, and transverse processes. This is continued distally as far as is necessary. The area of the significant kyphotic deformity is observed and the area of excision of vertebra is planned. Elevation of the dural sac from the vertebral body is performed with division and ligation of the nerve roots at the appropriate levels of excision. It is usually necessary to do this over at least four levels if the two level excision is planned. Elevation of the entire dural sac, paying attention to homeostasis is performed. The dissection is then continued in a circumferential manner around the vertebral bodies at the apex of the kyphosis. The dissection is continued by elevating the musculature anterior of the transverse processes on to the vertebral bodies. Careful attention is necessary to stay in the appropriate plane and avoid endangering the vena cava

or aorta. Circumferentially with homeostatic control, the vertebra is exposed for the appropriate levels. If two level excision is planned, it is usually necessary to expose circumferentially four vertebral bodies. Care is necessary because of the proximity of the aorta and vena cava. Following complete circumferential exposure, the vertebral body excision is planned. Should a step cut osteotomy for approximation be necessary, this is planned in the appropriate vertebral bodies, one or two of which are excised completely. The end plates of the adjacent vertebra are then prepared for fusion which is not a portion of this code. Correction of the deformity is then performed by elevating the legs to correct the kyphotic deformity. Care is extremely necessary because of the stretch that this may place on the vena cava and aorta. The potential for vascular catastrophe is significant at this time. Blood loss is replaced as is necessary and is often significant during the exposure and vertebral body excision. The arthrodesis and instrumentation which are separately codeable are then performed. Appropriate intra-operative x-rays are taken in planning the area of resection.

These are done in both AP and lateral plane and are reviewed for documentation and facilitation of the previously decided intra-operative plan. Following the performance of these procedures and bone grafting, the wound is closed in layers utilizing the dural sac to facilitate coverage over the vertebral bodies. Appropriate dressings are applied and the patient is turned supine and awakened.

Description of Post-Service Work:

The post-service work includes monitoring of the patient until stabilized in the operating room area with appropriate documentation of fluid loss and blood loss and replacement, as well as writing appropriate orders. Communication with the family and the necessary associated health care professionals which would include the intensive care physicians if present and the intensive care nurses that will assist in the care of the patient is performed. An operative note is dictated. X-rays are taken and reviewed to make sure that the lungs remain clear and there is no pneumothorax and the position of the back is appropriate. After the patient is awakened and recovery has been stabilized, the patient is transferred to the intensive care unit where appropriate monitoring is continued. The surgeon reviews all of the available information in regards to fluid balance, electrolytes, blood loss, and makes appropriate recommendations.

He will consult with the intensive care nurses in regards to the patients pulmonary function plans and with the intensive care physician if available.

Once the patient is stabilized, the surgeon leaves the area returning later on the day of surgery for a post-surgical visit to review the patient's status. The surgeon makes sure that the skin condition remains intact and the patient is appropriately mobilized. Log-rolling care to avoid pathological fractures to the extremities is communicated to the nursing staff. In each subsequent intensive care visit, which occur two times a day during the intensive care period, the surgeon assumes a significant portion of the intensive care responsibilities that are present. It should be noted that these visits involve medical decision making of high complexity. It should also be noted that a portion of the critical care may be given by a critical care physician. A significant portion however, is the responsibility of the surgeon. The critical care visits are most equivalent to 99233, subsequent hospital care, but because of the critical care physician involvement, it should be considered equivalent to 99232, subsequent hospital care. Subsequent care in the intensive care unit continues until the patient is clearly stabilized and the patient is transferred to the ward. At least daily hospital visits occur paying attention to the fluid status and blood replacement, as well as the urinary catheter drainage. Transition to intermittent catheterization is initiated. Once the patient begins to have bowel sounds, oral intake is begun and monitored. A thoracolumbosacral orthosis (TLSO) is usually fabricated and fit when available. When the TLSO is available, initiation of sitting in a wheelchair with careful attention to the status of the skin and the fit of the jacket on a daily basis is present. When the patient is sitting well in the TLSO and eating well without evidence of infection, the patient is then discharged to home or post-hospitalization facility care. Communication of the responsibilities to the provider of the patient's care in that situation is performed during the hospital visit and prior to discharge. Careful attention to communicate the necessities for transfer, skin care, and monitoring the patient's condition are present. Subsequent office visits are performed at which time x-rays are taken and evaluated. The skin condition under the orthosis is evaluated. The necessary laboratory data is evaluated. The urinary antibiotic usage during the post-operative period varies and is dependent on the prophylactic antibiotics used in surgery, as well as the necessary urinary antibiotics. Communication to the other health care involved providers of the patient's status is performed with each office visit.

SURVEY DATA:Specialty: American Academy of Pediatrics (AAP) and American Academy of Orthopaedic Surgeons (AAOS)Sample Size: n= 120 Response Rate (%): 35.83% (43) Median RVW: 30.0025th Percentile RVW: 25.00 75th Percentile RVW: 34.88 Low: 18 High: 65Median Pre-Service Time: 120 Minutes Median Intra-Service Time: 240 Minutes25th Percentile Intra-Svc Time: 180 Minutes 75th Percentile Intra-Svc Time: 300 MinutesLow: 60 Minutes High: 400 MinutesMedian Post-Service Time: Total Time Number of VisitsDay of Procedure: 60ICU: 60 3Other Hospital: 90 6Office: 90 3**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	63087	Vertebral corpectomy (vertebral body resection)	33.91
2)	22800	Arthrodesis, posterior, for spinal deformity	16.92
3)	22595	Arthrodesis, posterior technique, atlas-axis	18.19

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median/Mean Mental Effort & Judgment	Median/Mean Technical Skill & Physical Effort	Median/Mean Psychological Stress
228X1	120 Min	240 Min.	270 Min.	Median = 5.00 Mean = 4.55	Median = 5.00 Mean = 4.74	Median = 5.00 Mean = 4.69
63087	90 Min.	240 Min.	260 Min.	Median = 4.00 Mean = 4.36	Median = 5.00 Mean = 4.61	Median = 5.00 Mean = 4.55
22800	60 Min.	180 Min.	175 Min.	Median = 3.00 Mean = 3.33	Median = 4.00 Mean = 3.56	Median = 3.00 Mean = 3.22
22595	60 Min.	150 Min.	180 Min.	Median = 4.00 Mean = 4.00	Median = 4.00 Mean = 4.33	Median = 4.00 Mean = 4.17

Relationship of code being reviewed to key reference service(s):

•The majority of the survey respondents compared the new kyphectomy code (228X1) to CPT 63087 (vertebral corpectomy). The survey respondents found 228X1 to have similar, but slightly less physician work than CPT code

63087. However, the survey respondents found the complexity/intensity of 228x1 to be higher than for CPT 63087. CPT 63087 requires an exposure usually through the flank to the anterior aspects of the vertebral body involved with careful attention of preservation of aorta, ureter, and vena cava function. Because of the lack of significant deformity, the exposure is usually done in a classical manner. Exposure of 228X1 involves a circumferential vertebral body exposure of a very deformed spine. It also involves careful attention at preserving aorta, vena cava, and ureteral function without damaging the structures. Because of the deformity, the anatomical relationships vary greatly. The exposure involves many many more levels than CPT 63087. The survey respondents reviewed the mental effort and judgment, technical skill, physician effort, and psychological stress as being higher and at the maximum of the available complexity/intensity scale because of the difficulties with the exposure and potential for catastrophic events. The preservation of the dura sac is intricate to 228X1 in that removal has been associated with intracranial catastrophe secondary to acute hydrocephalus. However, since these patients are all paralyzed, preservation of neurological function is not present. CPT 63087 involves preservation or restoration of neurological function and preservation of the dura sac. 228X1 involves a significant vertebral body resection of one of two vertebral bodies in a planned manner to facilitate the technical approximation of the remaining vertebra.

- CPT 63087 involves removal of the anterior vertebral body only for purposes of exposure of the spinal canal and preparation for bone grafting. The bone grafting procedures in both cases represent additional codes.

- CPT 22800 and 22595 were selected as the second and third reference codes by some of the survey respondents. Both of these procedures represent spinal procedures involving less intra-operative time and significantly less mental judgment, technical skills, and stress as defined by the survey respondent data. The RVUs for CPT 22800 and 22595 are appropriately less than the recommended RVW for 228X1. The recommended RVW for 228X1 is consistent with the relationship of intra operative times of the three reference codes in comparison to the intra operative time of 228X1. It also reflects the relationship between the mental effort, stress and judgment involved in these procedures (see attached charts).

- Because the involved medical decision making is of high complexity, the critical care visits identified by the survey respondents should be considered most equivalent to CPT 99233 subsequent hospital visit. But because other physicians may be involved in this aspect of care, CPT 99232 subsequent hospital visit was considered more appropriate for the purpose of physician work comparison.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

Harvard and RUC Update intra time information for key reference services:

CPT Code	Descriptor	Global	Harvard Intra Time	RUC Update Intra Time	Survey Intra Time
63087	Vertebral corpectomy (vertebral body resection)	090	258 Minutes	N/A	240 Minutes
22800	Arthrodesis, posterior, for spinal deformity	090	170 Minutes	180 Minutes	180 Minutes
22595	Arthrodesis, posterior technique, atlas-axis	090	172 Minutes	150 Minutes	150 Minutes

The times assigned by the survey respondents to CPT code 63087, 22800, and 22595 are consistent with the times derived from the Hsiao (Harvard) data and the available RUC update information. This demonstrates that the survey was reliable for ascertaining the amount of physician time involved in providing these services (consistent with other mechanisms for determining physician time such as consensus panel) as well as maintaining external validity of survey results (the results being similar also substantiates the survey respondents results).

FREQUENCY INFORMATION

How was this service previously reported? CPT 63087

How often do physicians in your specialty perform this service? Commonly ☒ Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 150

Is this service performed by many physicians across the United States? Yes ☒ No

This procedure and 228X2 are performed approximately 150 times per year in the United States by fewer than 100 pediatric orthopaedic surgeons. The respondents to this survey represent the large majority of those physicians who commonly provide this procedure.

SUMMARY STATISTICS ON 228X1 AND REFERENCE SERVICES

228X1		SURVEYED SERVICE DATA															
		Pre	Intra	Post								Complex/Intense			RVW		
		Int.			DOP	ICU	ICU	O.Hosp	O.Hosp	Office	Office	TOTAL	ME	TS		Final RVW	
		RVW	min	min	min	visits	min	visits	min	visits	min	min	J	PE	PS		
SUM DATA:		low	16.00	30.00	60.00	15.00	0.00	0.00	2.00	10.00	1.00	15.00	55.00	3.00	3.00	4.00	18.00
		25th%	25.00	90.00	180.00	35.00	2.00	30.00	5.00	60.00	3.00	45.00	227.50	4.00	5.00	4.00	25.00
		med	30.00	120.00	240.00	60.00	3.00	60.00	6.00	90.00	3.00	60.00	270.00	5.00	5.00	5.00	30.00
svy n	120	75th%	34.88	170.00	300.00	90.00	4.00	117.50	8.00	120.00	4.00	90.00	355.00	5.00	5.00	5.00	34.88
resp.	43	high	50.00	480.00	400.00	480.00	12.00	200.00	12.00	360.00	10.00	300.00	900.00	5.00	5.00	5.00	65.00
rate %	36%	mean	29.68	131.05	238.49	76.98	3.39	73.10	6.24	103.66	3.85	76.34	320.00	4.55	4.74	4.69	31.13

Key Reference A Data															
		Pre	Intra	Post								Complex/Intense			
Key Ref A	Ref RVW	min	min	DOP min	ICU visits	ICU min	O.Hosp visits	O.Hosp min	Office visits	Office min	TOTAL min	ME J	TS PE	PS	
low	33.91	30.00	60.00	15.00	1.00	10.00	3.00	10.00	2.00	20.00	55.00	3.00	3.00	3.00	
25th%	33.91	82.50	180.00	45.00	2.00	30.00	5.00	60.00	3.00	45.00	190.00	4.00	4.00	4.00	
med	33.91	90.00	240.00	60.00	3.00	60.00	6.00	82.50	3.00	60.00	260.00	4.00	5.00	5.00	
75th%	33.91	135.00	300.00	60.00	4.00	87.50	7.00	100.00	4.00	85.00	330.00	5.00	5.00	5.00	
high	33.91	660.00	600.00	300.00	7.00	250.00	10.00	360.00	10.00	180.00	825.00	5.00	5.00	5.00	
mean	33.91	128.29	250.00	59.57	3.09	67.50	5.97	98.68	3.79	70.91	287.86	4.36	4.61	4.55	

Key Reference B Data															
		Pre	Intra	Post								Complex/Intense			
Key Ref B	Ref RVW	min	min	DOP min	ICU visits	ICU min	O.Hosp visits	O.Hosp min	Office visits	Office min	TOTAL min	ME J	TS PE	PS	
low	16.92	45.00	60.00	15.00	0.00	0.00	4.00	10.00	1.00	20.00	55.00	3.00	3.00	2.00	
25th%	16.92	60.00	150.00	30.00	0.00	0.00	4.75	57.50	2.00	30.00	135.00	3.00	3.00	3.00	
med	16.92	60.00	180.00	40.00	1.00	20.00	5.00	60.00	3.00	45.00	175.00	3.00	4.00	3.00	
75th%	16.92	90.00	180.00	60.00	2.00	30.00	6.00	76.25	4.00	60.00	220.00	4.00	4.00	4.00	
high	16.92	120.00	300.00	120.00	2.00	60.00	6.00	150.00	6.00	100.00	330.00	4.00	4.00	4.00	
mean	16.92	77.22	168.89	52.78	1.00	19.44	5.13	68.13	3.00	48.89	181.67	3.33	3.56	3.22	

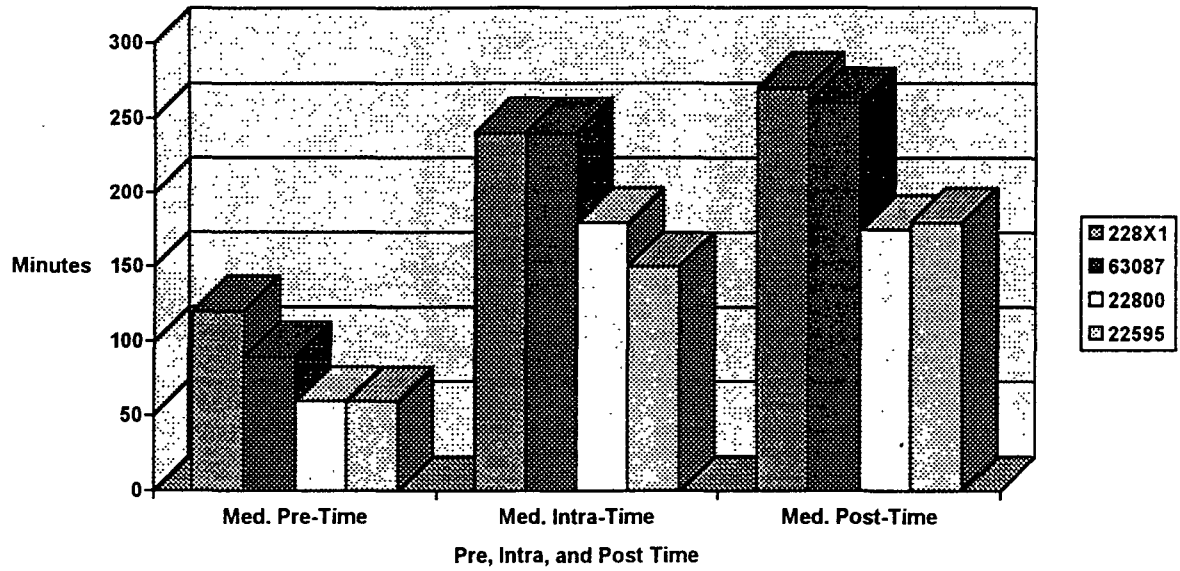
228X1

			Key Reference C Data												
			Pre	Intra	Post								Complex/Intense		
22595	Key Ref C	Ref RVW	min	min	DOP min	ICU visits	ICU min	O.Hosp visits	O.Hosp min	Office visits	Office min	TOTAL min	ME J	TS PE	PS
	low	18.19	30.00	120.00	15.00	0.00	0.00	2.00	30.00	1.00	15.00	75.00	3.00	4.00	3.00
	25th%	18.19	60.00	127.50	32.50	0.00	0.00	3.00	35.00	2.25	30.00	123.75	4.00	4.00	4.00
	med	18.19	60.00	150.00	50.00	0.50	7.50	3.50	55.00	3.00	37.50	180.00	4.00	4.00	4.00
	75th%	18.19	60.00	172.50	60.00	1.00	18.75	4.75	82.50	3.00	56.25	217.50	4.00	4.75	4.75
	high	18.19	105.00	240.00	120.00	2.00	30.00	6.00	90.00	3.00	90.00	240.00	5.00	5.00	5.00
	mean	18.19	62.50	160.00	54.17	0.67	10.83	3.83	58.33	2.50	45.00	168.33	4.00	4.33	4.17

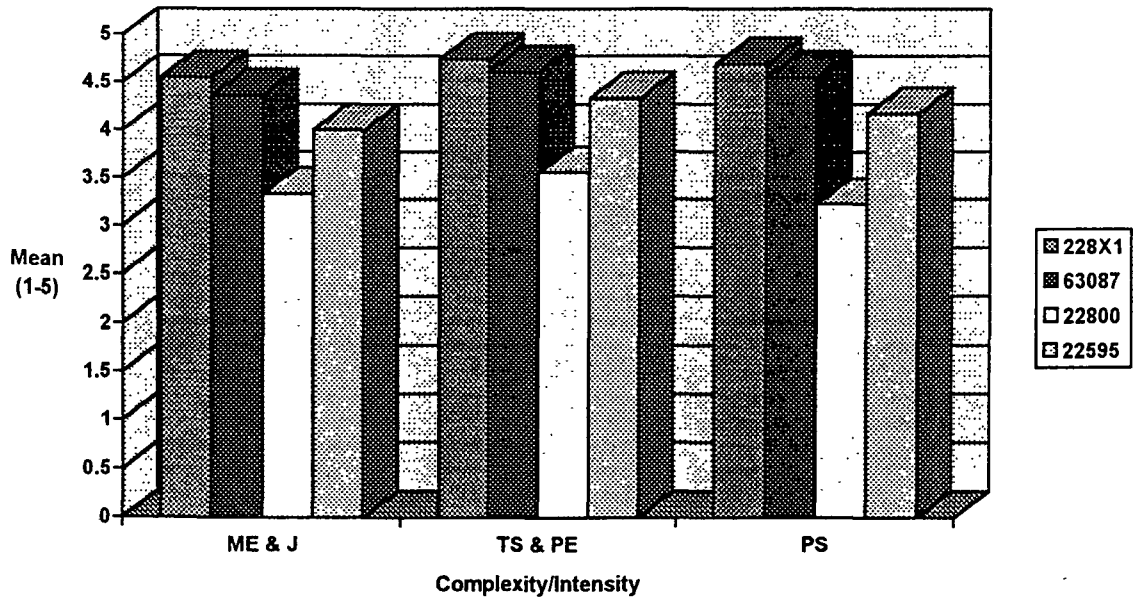
228X1

Times Services Provided			T. Patient			
	New	Ref A	Ref B	Ref C	Yes	NO
Low	0.00	0.00	0.00	0.00		
25%	0.00	0.00	0.50	0.00		
Med	1.00	1.00	7.50	0.00	Total	Total
75%	2.00	2.00	20.00	1.00		
High	4.00	7.00	50.00	4.00		
Mean	1.23	1.31	13.20	0.67	28.00	2.00

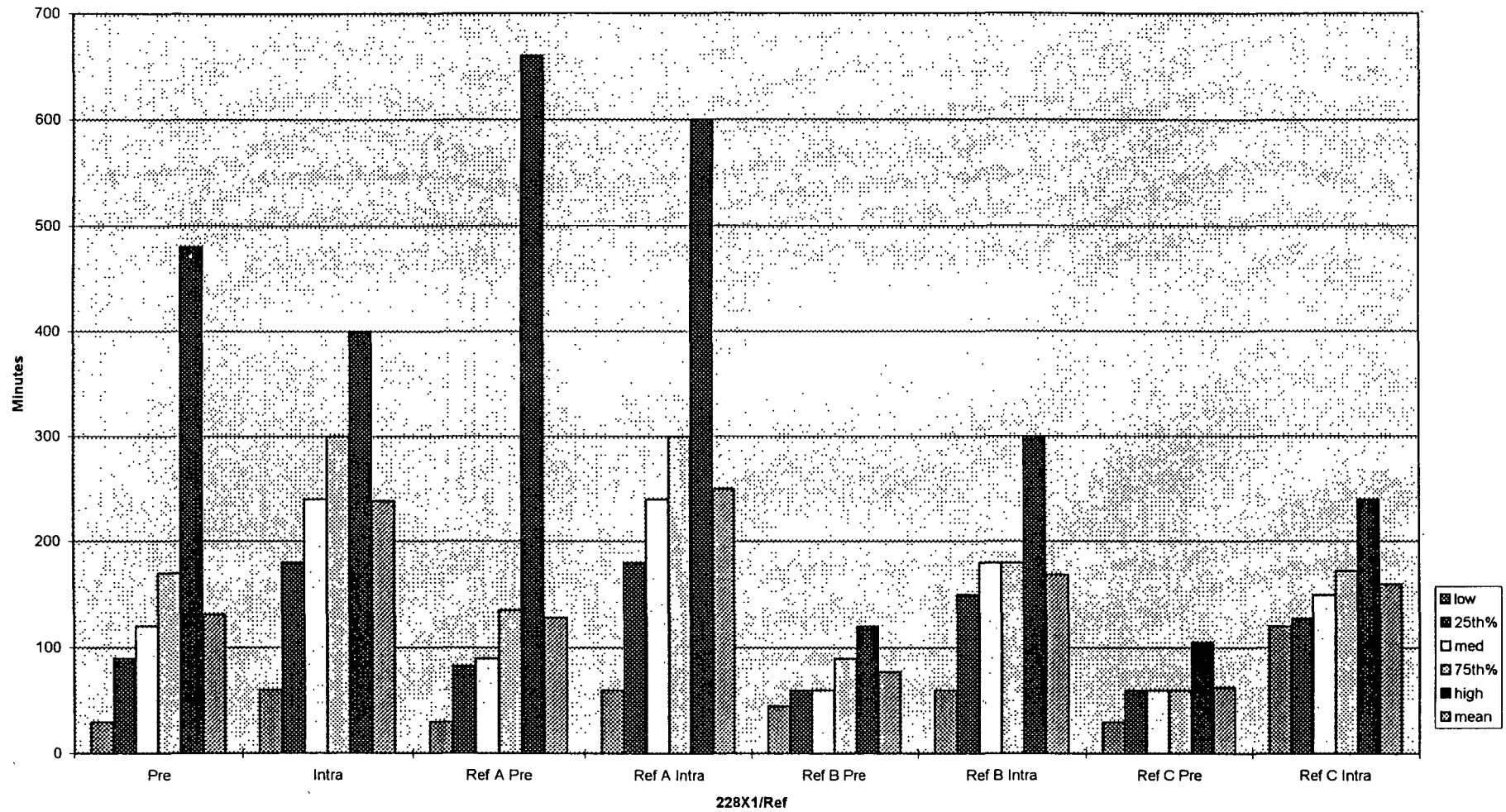
228X1 and CPT Code References Time Comparison



228X1 and CPT Code References Comparison



228X1 RWV Information



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

CPT Code: 228X2 Tracking Number: AA2 Global Period: 090 Recommended RVW: 34.50

CPT Descriptor:

Kypsectomy, circumferential exposure of spine and resection of vertebral segments (including body and posterior elements), 3 or more segments.
(To report arthrodesis, see 22800 - 22804 and use Modifier - 51)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

An 8 year old thoracic level myelomeningocele patient with progressive congenital kyphotic deformity undergoes kypsectomy with resection of L1, L2, and L3 involving a circumferential exposure via posterior approach. (Note: Associated arthrodesis, instrumentation and bone grafting are not included in this code and are reported separately.

Description of Pre-Service Work:

In the 24 hours prior to surgery, the surgeon has reviewed the previously obtained preliminary laboratory data including urinalysis and possibly urine cultures. Because of the high incidence of associated urinary tract infections in spina bifida patients, appropriate urinary antibiotics is reviewed. Pre-operative x-rays and imaging studies are gathered and reviewed, as well as any preliminary associated studies such as pulmonary function tests. One the morning of surgery, all information is reviewed and the patient is re-examined paying particular attention to the condition of the skin in the area of the kyphotic deformity, as well as pulmonary function and the condition of the patient's urine. The surgeon checks on the availability of blood for the necessary transfusions. The family and patient are counseled and the operative risks and benefits are reviewed once again. After dressing, the surgeon assists in positioning the patient after appropriate general anesthesia is available and appropriate intravenous and intra-arterial lines including urinary catheter have been placed. The surgeon often assists in placement of these lines. The surgeon positions the patient on the operating table paying particular attention to padding the iliac crests and chest, as well as the legs. It should be noted that in the patient without sensation, appropriate protection is necessary for this lengthy procedure. The physician reviews the available surgical instrumentation which has been previously selected, as well as the making sure that all supplies that are necessary are present and available in the operative suite. The physician supervises the prepping of the patient and drapes the patient to expose the area of the surgical procedure. In addition, the surgeon prepares for the radiographic imaging control that will be necessary during surgery.

Because the increased deformity that is present in the patients requiring 228X2, positioning is significantly more difficult as is the importance of the pre-operative planning for the area of resection than in 228X1. This pre-operative planning review is a significant portion of the pre-service work.

Description of Intra-Service Work:

The mid-line incision is made through the length of the planned procedure. Because of the previously closed spina bifida over the area of the kyphotic deformity it is not possible to make an incision to level of the spinous process as these remain open. The incision begins at the areas of intact spinous processes proximal to the spina bifida lesion. Careful dissection elevating the musculature and periosteum of spinous processes, facet joints and transverse processes is performed. This is continued distally at each level of exposure starting at least two levels proximal to the spina bifida defect. As the spina bifida defect is encountered, the exposure is lateral to the defect. The musculature is elevated from the displaced spinous processes on the right and left sides, facet joints, and transverse processes. This is continued distally as far as is necessary. The area of the significant kyphotic deformity is observed and the area of excision of vertebra is planned. Elevation of the dural sac from the vertebral body is performed with division and

ligation of the nerve roots at the appropriate levels of excision. It is usually necessary to do this over at least four levels if the tow level excision is planned. Elevation of the entire dural sac, paying attention to homeostasis is performed. The dissection is then continued in a circumferential manner around the vertebral bodies at the apex of the kyphosis. The dissection is continued by elevating the musculature anterior of the transverse processes on to the vertebral bodies. Careful attention is necessary to stay in the appropriate plane and avoid endangering the vena cava or aorta. Circumferentially with homeostatic control, the vertebra is excised for the appropriate several levels. If three level excision is planned, it is usually necessary to expose circumferentially five vertebral bodies. At the extremes of the exposure, care is necessary because of the proximity of the aorta and vena cava. Following complete circumferential exposure, the vertebral body excision is planned. Should a step cut osteotomy for approximation be necessary, this is planned in the appropriate vertebral bodies, three or more of which are excised completely. The end plates of the adjacent vertebra are then prepared for fusion which is not a portion of this code. Correction of the deformity is then performed by elevating the legs to correct the kyphotic deformity. Care is extremely necessary because of the stretch that this may place on the vena cava and aorta. The potential for vascular catastrophe is significant at this time. Blood loss is replaced as is necessary and is often significant at this portion of time. Blood loss is replaced as is necessary and is often significant during the exposure and vertebral body excision. The arthrodesis and instrumentation which are separately codeable are then performed. Appropriate intra-operative x-rays are taken in planning the area of resection. These are done in both AP and lateral plane and are reviewed for documentation and facilitation of the previously decided intra-operative plan. Following the performance of these procedures and bone grafting, the wound is closed in layers utilizing the dural sac to facilitate coverage over the vertebral bodies. Appropriate dressings are applied and the patient is turned supine and awakened.

Because of the increased deformity that is reflected in this group of patients, a more extensive exposure of the vertebral column is necessary both proximally and distally. This exposure gives the potential for entering the chest cavity. The possibility of needing chest tube placement is present. The possibility of endangering the ureters, vena cava or aorta is more significant. Because of the increased kyphotic deformity present in these patients, a more extensive area of vertebral resection is necessary. Careful planning of the area of vertebral resection of three or more levels is present. This planning and the surgical performance of this portion of the procedure must allow approximation of the remaining vertebra as the entire pelvis is extended on the operating table. Because of the severity of the deformity present in these patients, the potential for catastrophic event during the correction of the severe deformity is more likely. The need for chest tube placement is evaluated both clinically and with x-ray control of the correction intra-operatively is present.

Description of Post-Service Work:

The post-service work includes monitoring of the patient until stabilized in the operating room area with appropriate documentation of fluid loss and blood loss and replacement, as well as writing appropriate orders. Communication with the family and the necessary associated health care professionals which would include the intensive care physicians if present and the intensive care nurses that will assist in the care of the patient is performed. An operative note is dictated. X-rays are taken and reviewed to make sure that the lungs remain clear and there is no pneumothorax and the position of the back is appropriate. After the patient is awakened and recovery has been stabilized, the patient is transferred to the intensive care unit where appropriate monitoring is continued. The surgeon reviews all of the available information in regards to fluid balance, electrolytes, blood loss, and makes appropriate recommendations. he will consult with the intensive care nurses in regards to the patients pulmonary function plans and with the intensive care physician if available.

Once the patient is stabilized, the surgeon leaves the area returning later on the day of surgery for a post-surgical visit to review the patient's status. The surgeon makes sure that the skin condition remains intact and the patient is appropriately mobilized. Log-rolling care to avoid pathological fractures to the extremities is communicated to the nursing staff. In each subsequent intensive care visit, which occur two times a day during the intensive care period, the surgeon assumes a significant portion of the intensive care responsibilities that are present. It should be noted that these visits involve medical decision making of high complexity. It should also be noted that a portion of the critical care may be given by a critical care physician. A significant portion however, is the responsibility of the surgeon. The critical care visits are most equivalent to 99233, subsequent hospital care, but because of the critical care physician involvement, it should be considered equivalent to 99232, subsequent hospital care. Subsequent care in the intensive care unit continues until the patient is clearly stabilized and the patient is transferred to the ward. At least

daily hospital visits occur paying attention to the fluid status and blood replacement, as well as the urinary catheter drainage. Transition to intermittent catheterization is initiated. Once the patient begins to have bowel sounds, oral intake is begun and monitored. A thoracolumbosacral orthosis (TLSO) is usually fabricated and fit when available. When the TLSO is available, initiation of sitting in a wheelchair with careful attention to the status of the skin and the fit of the jacket on a daily basis is present. When the patient is sitting well in the TLSO and eating well without evidence of infection, the patient is then discharged to home or post-hospitalization facility care. Communication of the responsibilities to the provider of the patient's care in that situation is performed during the hospital visit and prior to discharge. Careful attention to communicate the necessities for transfer, skin care, and monitoring the patient's condition are present. Subsequent office visits are performed at which time x-rays are taken and evaluated. The skin condition under the orthosis is evaluated. The necessary laboratory data is evaluated. The urinary antibiotic usage during the post-operative period varies and is dependent on the prophylactic antibiotics used in surgery, as well as the necessary urinary antibiotics. Communication with the other providers involved with the health care of the patient's are informed of the patient's status after each office visit.

Post-service work of 228X2 is similar but more elaborate than 228X1. Because of the severity of the deformity and resultant in correction, additional days of hospitalization in the intensive care unit may be necessary. The possibility of chest tube placement, unilateral or bilateral with appropriate care is also present.

SURVEY DATA:

Specialty: American Academy of Pediatrics (AAP) and American Academy of Orthopaedic Surgeons (AAOS)

Sample Size: n= 120 Response Rate (%): 31.67% (38) Median RVW: 34.50

25th Percentile RVW: 26.00 75th Percentile RVW: 37.75 Low: 18.50 High: 60

Median Pre-Service Time: 120 Minutes Median Intra-Service Time: 245 Minutes

25th Percentile Intra-Svc Time: 220 Min. 75th Percentile Intra-Svc Time: 322.5 Min. Low: 80 Min. High: 480 Min.

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 60

ICU: 60 3

Other Hospital: 90 7

Office: 65 4

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	63087	Vertebral corpectomy (vertebral body resection)	33.91
2)	22800	Arthrodesis, posterior, for spinal deformity	16.92
3)	22595	Arthrodesis, posterior technique, atlas-axis	18.19

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median/Mean Mental Effort & Judgment	Median/Mean Technical Skill & Physical Effort	Median/Mean Psychological Stress
228X2	120 Min	245 Min.	287.5 Min	Median = 5.00 Mean = 4.61	Median = 5.00 Mean = 4.82	Median = 5.00 Mean = 4.74
63087	90 Min.	240 Min.	250 Min.	Median = 4.00 Mean = 4.32	Median = 5.00 Mean = 4.64	Median = 5.00 Mean = 4.54
22800	60 Min.	150 Min.	220 Min.	Median = 3.00 Mean = 3.29	Median = 4.00 Mean = 3.57	Median = 3.00 Mean = 3.14
22595	60 Min.	150 Min.	210 Min.	Median = 4.00 Mean = 4.00	Median = 4.00 Mean = 4.29	Median = 4.00 Mean = 4.14

Relationship of code being reviewed to key reference service(s):

•The majority of the survey respondents compared the new kyphectomy code (228X2) to CPT 63087 (vertebral corpectomy). The survey respondents found 228X2 to have similar, but slightly more physician work than CPT code 63087. The survey respondents also found the complexity/intensity of 228X2 to be higher than for CPT 63087. CPT 63087 requires an exposure usually through the flank of the anterior aspects of the vertebral body involved with careful attention of preservation of aorta, ureter, and vena cava function. Because of the lack of significant deformity, the exposure is usually done in a classical manner. However, exposure of 228X2 involves a circumferential vertebral body exposure of a very deformed spine. It involves careful attention at preserving aorta, vena cava, and ureteral function without damaging the structures. Because of the deformity, the anatomical relationships vary greatly. The exposure involves many additional levels than CPT 63087. The respondents reviewed the mental effort and judgment, technical skill, physician effort, and psychological stress as being higher and at the maximum of the available complexity/intensity scale because of the difficulties with the exposure and potential for catastrophic events. The preservation of the dura sac is intricate to 228X2 in that removal has been associated with intracranial catastrophe secondary to acute hydrocephalus. However, since these patients are all paralyzed, preservation of neurological function is not present. CPT 63087 involves preservation or restoration of neurological function and preservation of the dural sac. 228X2 involves a significant vertebral body resection of two or more vertebral bodies in a planned manner to facilitate the technical approximation of the remaining vertebra whereas CPT 63087 requires less deformity correction.

•CPT 63087 involves removal of the anterior vertebral body only for purposes of exposure of the spinal canal and preparation for bone grafting. The bone grafting procedures in both cases represent additional codes.

•228X2 involves significantly more exposure than 228X1 with more danger of entering the chest cavities and more risk to the aorta, vena cava, and ureters. In addition, larger vertebra excision is present.

•Deliberations of the AMA/Specialty Society Relative Value Scale Update Committee (RUC) during the spine code evaluation involved some debate regarding additional levels. As a check of the relationship between 228X1 and 228X2, the previous methodology utilized in consideration of 22114 and 22116 has been employed. The relative value of the spine codes was increased 16.68 percent for the additional level. The recommendation of the relative work to 228X2 represents and increased work value of 15 percent compared to 228X1. This methodology is consistent with prior RUC processes and the comparison is being used as a validation technique for the survey results and recommendations for 228X1 and 228X2 (see attached spine code evaluation summary form). Harvard's Phase IV study established a range of 16.31% for additional levels.

•CPT 22800 and 22595 were selected as the second and third reference codes by some of the survey respondents. Both of these procedures represent spinal procedures involving significantly less intra-operative time and significantly less mental judgment, technical skills, and stress as defined by the survey respondent data. The RVUs for CPT 22800 and 22595 are appropriately less than the recommended RVW for 228X2. The recommended RVW for 228X1 is consistent with the relationship of intra operative times of the three reference codes in comparison to the intra operative time of 228X2. It also reflects the relationship between the mental effort, stress and judgment involved in these procedures (see attached charts).

•Because the involved medical decision making is of high complexity, the critical care visits identified by the survey respondents should be considered most equivalent to CPT 99233 subsequent hospital visit. But because other physicians may be involved in this aspect of care, CPT 99232 subsequent hospital visit was considered more appropriate for the purpose of physician work comparison.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

Harvard and RUC Update intra time information for key reference services

CPT Code	Descriptor	Global	Harvard Intra Time	RUC Update Intra Time	Survey Intra Time
63087	Vertebral corpectomy (vertebral body resection)	090	258 Minutes	N/A	240 Minutes
22800	Arthrodesis, posterior, for spinal deformity	090	170 Minutes	180 Minutes	150 Minutes
22595	Arthrodesis, posterior technique, atlas-axis	090	172 Minutes	150 Minutes	150 Minutes

The times assigned by the survey respondents to CPT code 63087, 22800, and 22595 are consistent with the times derived from the Hsiao (Harvard) data and the available RUC update information. This demonstrates that the survey was reliable for ascertaining the amount of physician time involved in providing these services (consistent with other mechanisms for determining physician time such as consensus panel) as well as maintaining external validity of survey results (the results being similar also substantiates the survey respondents results).

FREQUENCY INFORMATION

How was this service previously reported? CPT 63087

How often do physicians in your specialty perform this service? Commonly ☒ Sometimes ☐ Rarely ☐

Estimate the number of times this service might be provided nationally in a one-year period? 150

Is this service performed by many physicians across the United States? ☐ Yes ☒ No

This procedure and 228X1 are performed approximately 150 times per year in the United States by fewer than 100 pediatric orthopaedic surgeons. The respondents to this survey represent the large majority of those physicians who commonly provide this procedure.

SUMMARY STATISTICS ON 228X2 AND REFERENCE SERVICES

228X2			SURVEYED SERVICE DATA															
			Pre		Intra	Post							Complex/Intense			RVW		
			Int. RVW	min	min	DOP min	ICU visits	ICU min	O.Hosp visits	O.Hosp min	Office visits	Office min	TOTAL min	ME J	TS PE	PS	Final RVW	
low			16.00	30.00	80.00	20.00	0.00	0.00	3.00	30.00	1.00	15.00	135.00	3.00	4.00	4.00	18.50	
25th%			24.00	90.00	220.00	45.00	2.00	32.50	5.00	60.00	3.00	45.00	231.25	4.00	5.00	4.25	26.00	
SUM DATA:			med	32.00	120.00	245.00	60.00	3.00	60.00	7.00	90.00	4.00	65.00	287.50	5.00	5.00	5.00	34.50
svy n	120	75th%	35.00	175.00	322.50	90.00	4.00	96.25	8.00	120.00	5.00	100.00	353.75	5.00	5.00	5.00	37.75	
resp.	47	high	60.00	480.00	480.00	480.00	10.00	180.00	12.00	360.00	12.00	180.00	1020.00	5.00	5.00	5.00	60.00	
rate %	39%	mean	31.29	140.79	270.92	82.11	3.46	72.24	6.78	111.76	4.17	77.84	338.95	4.61	4.82	4.74	33.29	

Key Reference A Data																
			Pre	Intra	Post								Complex/Intense			
63087	Key Ref A	Ref RVW	min	min	DOP min	ICU visits	ICU min	O.Hosp visits	O.Hosp min	Office visits	Office min	TOTAL min	ME J	TS PE	PS	
	low	33.91	30.00	60.00	15.00	1.00	20.00	2.00	30.00	2.00	30.00	135.00	3.00	3.00	3.00	
	25th%	33.91	70.00	180.00	45.00	2.00	30.00	5.00	60.00	3.00	45.00	198.75	4.00	4.00	4.00	
	med	33.91	90.00	240.00	55.00	3.00	60.00	6.00	90.00	3.00	60.00	250.00	4.00	5.00	5.00	
	75th%	33.91	120.00	300.00	60.00	4.00	80.00	7.00	100.00	4.25	90.00	333.75	5.00	5.00	5.00	
	high	33.91	360.00	600.00	360.00	56.00	250.00	12.00	360.00	12.00	180.00	825.00	5.00	5.00	5.00	
	mean	33.91	118.50	241.33	63.50	4.90	67.83	6.28	105.67	4.14	71.72	306.33	4.32	4.64	4.54	

Key Reference B Data																
			Pre	Intra	Post								Complex/Intense			
22800	Key Ref B	Ref RVW	min	min	DOP min	ICU visits	ICU min	O.Hosp visits	O.Hosp min	Office visits	Office min	TOTAL min	ME J	TS PE	PS	
	low	16.92	45.00	60.00	30.00	0.00	0.00	4.00	50.00	2.00	30.00	120.00	3.00	3.00	2.00	
	25th%	16.92	60.00	130.00	45.00	0.50	10.00	5.00	52.50	2.50	45.00	162.50	3.00	3.00	3.00	
	med	16.92	90.00	150.00	60.00	1.00	25.00	5.50	60.00	4.00	60.00	220.00	3.00	4.00	3.00	
	75th%	16.92	105.00	240.00	90.00	2.00	30.00	6.00	71.25	5.00	80.00	232.50	3.50	4.00	3.50	
	high	16.92	360.00	330.00	240.00	2.00	60.00	6.00	80.00	6.00	100.00	450.00	4.00	4.00	4.00	
	mean	16.92	117.86	182.86	85.71	1.14	23.57	5.33	62.50	3.86	62.86	225.71	3.29	3.57	3.14	

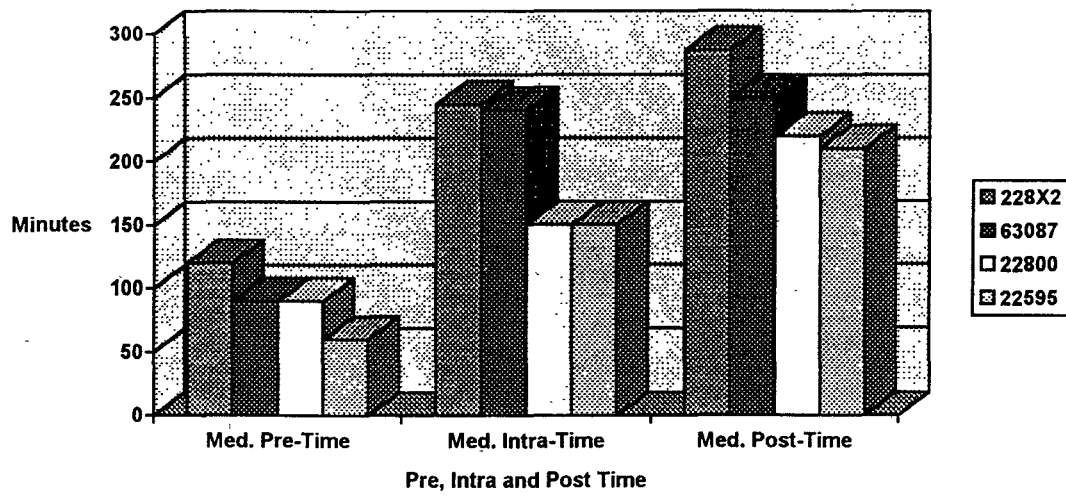
228X2

			Key Reference C Data												
			Pre	Intra	Post								Complex/Intense		
22595	Key Ref C	Ref RVW	min	min	DOP min	ICU visits	ICU min	O.Hosp visits	O.Hosp min	Office visits	Office min	TOTAL min	ME J	TS PE	PS
	low	18.19	30.00	120.00	15.00	0.00	0.00	2.00	30.00	1.00	15.00	75.00	3.00	4.00	3.00
	25th%	18.19	60.00	135.00	30.00	0.00	0.00	3.00	40.00	2.50	30.00	132.50	4.00	4.00	4.00
	med	18.19	60.00	150.00	40.00	1.00	15.00	4.00	60.00	3.00	45.00	210.00	4.00	4.00	4.00
	75th%	18.19	82.50	180.00	60.00	1.50	25.00	5.50	90.00	3.00	60.00	230.00	4.00	4.50	4.50
	high	18.19	120.00	270.00	120.00	2.00	30.00	6.00	120.00	4.00	90.00	240.00	5.00	5.00	5.00
	mean	18.19	70.71	167.14	50.71	0.86	13.57	4.14	67.14	2.71	47.14	178.57	4.00	4.29	4.14

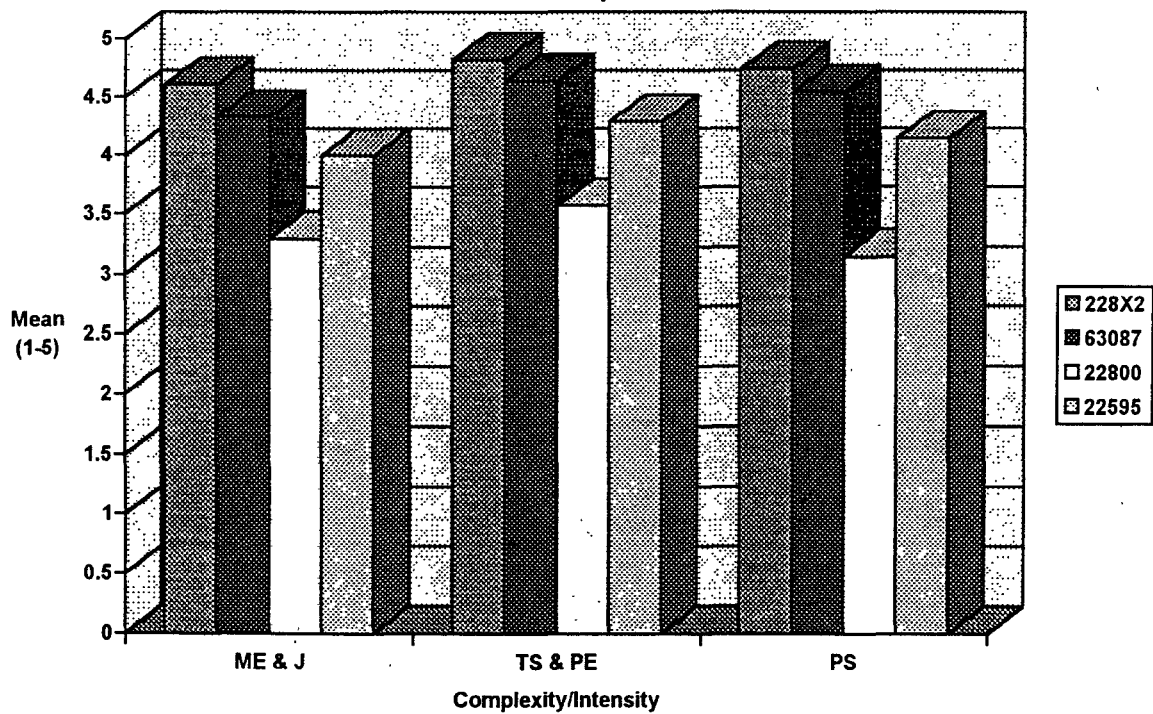
228X2

Times Service Provided		T. Patient					
	New	Ref A	Ref B	Ref C	Yes	NO	
low	0.00	0.00	0.00	0.00			
25th%	0.00	0.00	3.00	0.00			
med	1.00	5.00	20.00	1.00	Total	Total	
75th%	2.00	2.50	22.50	1.50			
high	4.00	7.00	50.00	4.00			
mean	1.39	1.71	17.29	1.14	23.00	0.00	

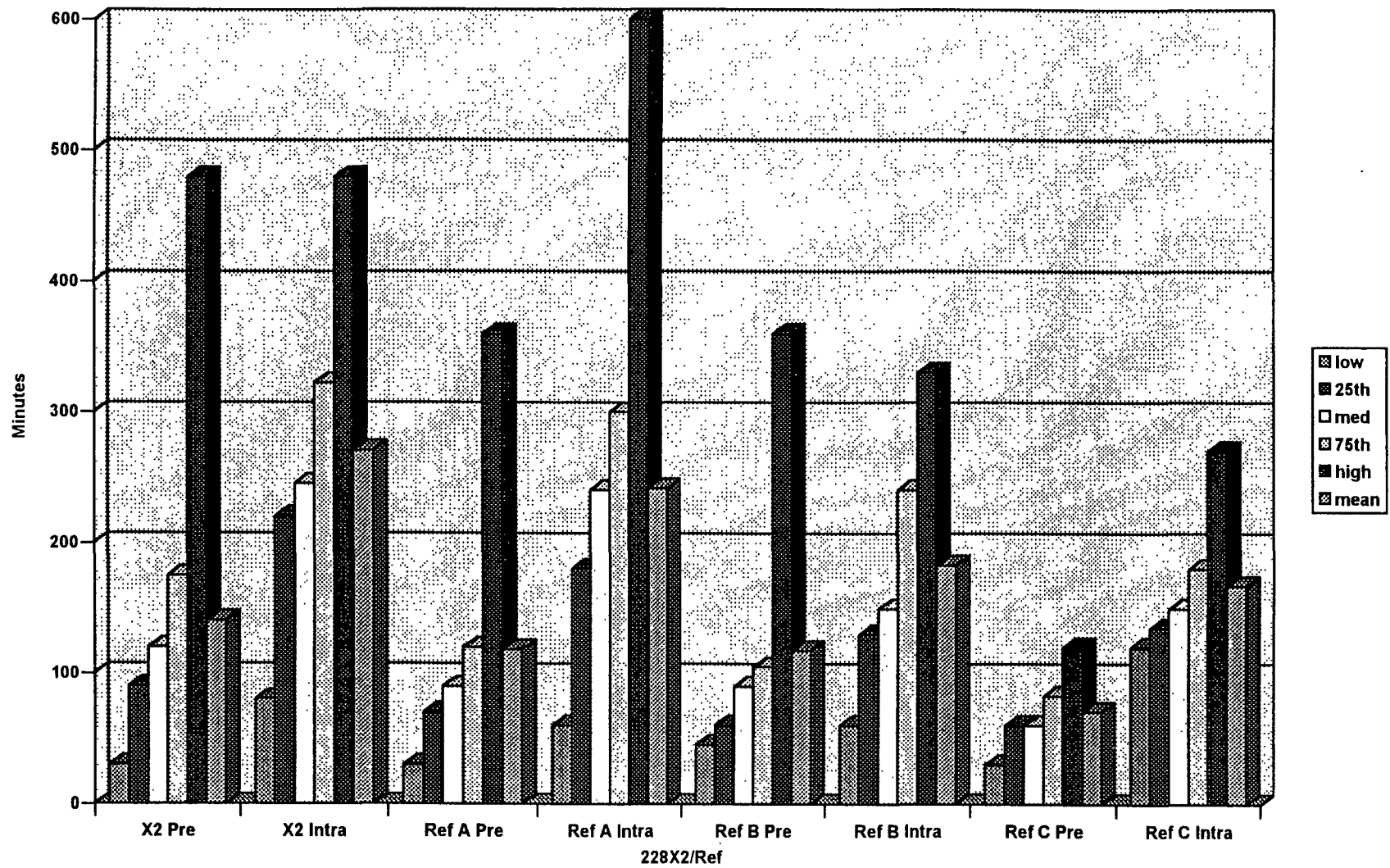
228X2 and CPT Code References Time Comparison



228X2 and CPT Code References Comparison



228X2 RVW Information



AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
FEBRUARY 1997

Echography of Infant Hip - Tab 26

The RUC recommends that code 76885 *Echography of infant hips, real time with imaging documentation; dynamic (eg, requiring manipulation)* be assigned a work rvu of .74, based on the survey of nearly 60 radiologists and pediatricians. The work is equivalent to code 76770 *Echography, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; complete* (work rvu = .74). A physician should be in attendance during this service and will typically manipulate the infant's hip.

The RUC recommends a work rvu of .62 for new CPT codes 76886 *Echography of infant hips, real time with imaging documentation; limited, static (eg, not requiring manipulation)*. This recommendation is also based on the radiology/pediatrics survey results. The infant is typically in a harness or cast. Code 76880 *Echography, extremity, non-vascular, B-scan and/or real time with image documentation* (.59) is similar in work to this new service.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•76885	Z1	Echography of infant hips, real time with imaging documentation; dynamic (eg, requiring manipulation)	XXX	0.74
•76886	Z2	limited, static (eg, not requiring manipulation)	XXX	0.62

See Attachment

SURVEY DATA:

Specialty: American College of RadiologySample Size: 140 Response Rate (%): 30.7% (N=43) Median RVW: 0.7525th Percentile RVW: 0.65 75th Percentile RVW: 0.85 Lowest RVW: 0.45 Highest RVW: 2.00Median Total Service Time: 20 minutes 25th Percentile Total Service Time: 18 minutes75th Percentile Total Service Time: 30 minutes Lowest Total Time: 10 minutesHighest Total Time: 45 minutesSpecialty: American Academy of PediatricsSample Size: 79 Response Rate (%): 19% (N=15) Median RVW: 0.7125th Percentile RVW: 0.64 75th Percentile RVW: 0.78 Lowest RVW: 0.51 Highest RVW: 0.87Median Total Service Time: 20 minutes 25th Percentile Total Service Time: 18 minutes75th Percentile Total Service Time: 30 minutes Lowest Total Time: 0 minutesHighest Total Time: 40 minutes

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Societies</u>
1)	76700	Echography, abdominal, B-scan and/or real time with image documentation; complete	0.81	ACR/AAP
2)	76770	Echography, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; complete	0.74	ACR/AAP
3)	76880	Echography, extremity, non-vascular, B-scan and/or real time with image documentation	0.59	ACR

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

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Total Time		Median Mental Effort & Judgment		Median Technical Skill & Physical Effort		Median Psychological Stress	
	ACR	AAP	ACR	AAP	ACR	AAP	ACR	AAP
768X1	20	20	4	3	4	4	3	3
76700	17.5	20	3	3.5	3	3.5	3	3
76770	15	18.5	3	3	3	2.5	3	3
76880	15	NA	3	NA	3	NA	3	NA

	ACR	AAP
Number of times performed in last 12 months (median)	40	30
Agree with vignette?	Yes (97%, N=34) No (3%, N=1)	Yes (100%, N=12)

ADDITIONAL RATIONALE

The recommended RVW is based on the survey median RVWs from the ACR and the AAP weighted by the number of survey respondents to the respective surveys.

FREQUENCY INFORMATION

How was this service previously reported? 76999 (Unlisted ultrasound procedure)

How often do physicians in your specialty perform this service?

Commonly X Sometimes Rarely

Estimate the number of times this service might be performed nationally in a one-year period? unable to quantify

Is this service performed by many physicians across the United States? Yes X No

Clinical Description of Service and Vignette

Code: 768X1 Echography of infant hips, real time with imaging documentation, dynamic (e.g. requiring manipulation)

Clinical Vignette:

An infant presenting with either a hip click, abnormal buttocks crease and/or instability or with predisposing factors for developmental dysplasia of the hip.

Description of Physician Work Associated With This Procedure:

Pre-Service Physician Work:

- Review history and physical exam.

Intra-Service Physician Work:

Note: Hips treated for developmental dysplasia may be examined in and out of a Pavlek harness or out of a cast.

- Obtain ultrasonic images from longitudinal, transverse, and coronal planes.
- Image the hip in a relaxed state.
- Repeat imaging utilizing hip compression to demonstrate stability of lack thereof.
- Obtain measurements of the acetabular angle for documenting dysplasia.

Post-Service Physician Work:

- Discuss results with patient's parents.
- Dictate, correct, and sign report.
- Discuss and communicate report/findings with referring physician(s).

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION
American College of Radiology
American Academy of Pediatrics

CPT Code: 768X2 Tracking Number: Z2 Global Period: XXX Recommended RVW: 0.62

CPT Descriptor: Echography of infant hips, real time with imaging documentation, limited, static
(e.g. not requiring manipulation)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

An infant presenting with or without a hip click, abnormal buttocks creases and/or instability or with or without predisposing factors for developmental dysplasia of the hip.

Description of Pre-Service Work:

See Attachment

Description of Intra-Service Work:

See Attachment

Description of Post-Service Work:

See Attachment

SURVEY DATA:

Specialty: American College of RadiologySample Size: 140 Response Rate (%): 19.3% (N=27) Median RVW: 0.6125th Percentile RVW: 0.57 75th Percentile RVW: 0.78 Lowest RVW: 0.35 Highest RVW: 1.80Median Total Service Time: 15 minutes 25th Percentile Total Service Time: 12 minutes75th Percentile Total Service Time: 20 minutes Lowest Total Time: 10 minutesHighest Total Time: 35 minutesSpecialty: American Academy of PediatricsSample Size: 79 Response Rate (%): 15% (N=12) Median RVW: 0.6525th Percentile RVW: 0.54 75th Percentile RVW: 0.76 Lowest RVW: 0.31 Highest RVW: 0.90Median Total Service Time: 20 minutes 25th Percentile Total Service Time: 15 minutes75th Percentile Total Service Time: 25 minutes Lowest Total Time: 0 minutesHighest Total Time: 40 minutes

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Societies</u>
1)	76705	Echography, abdominal. B-scan and/or real time with image documentation; limited (eg, single organ, quadrant, follow-up)	0.59	ACR/AAP
2)	76770	Echography, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; complete	0.74	ACR
3)	76880	Echography, extremity, non-vascular, B-scan and/or real time with image documentation	0.59	ACR
4)	76856	Echography, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete	0.69	AAP

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

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Total Time		Median Mental Effort & Judgment		Median Technical Skill & Physical Effort		Median Psychological Stress	
	ACR	AAP	ACR	AAP	ACR	AAP	ACR	AAP
768X2	15	20	3	3	3.5	4	3	3
76700	20	16	3	2.5	3	3	3	2.5
76770	15	NA	3	NA	3	NA	3	NA
76880	15	NA	3	NA	4	NA	3	NA
76856	NA	27.5	NA	2.5	NA	3	NA	3

	ACR	AAP
Number of times performed in last 12 months (median)	20	33
Agree with vignette?	Yes (89.5%, N=17) No (10.5%, N=2)	Yes (100%, N=6)

 ADDITIONAL RATIONALE

The recommended RVW is based on the survey median RVWs from the ACR and the AAP weighted by the number of survey respondents to the respective surveys.

 FREQUENCY INFORMATION

How was this service previously reported? 76999 (Unlisted ultrasound procedure)

How often do physicians in your specialty perform this service?

Commonly X Sometimes Rarely

Estimate the number of times this service might be performed nationally in a one-year period? unable to quantify

Is this service performed by many physicians across the United States? Yes X No

Clinical Description of Service and Vignette

Code: 768X2 Echography of infant hips, real time with imaging documentation, static (e.g. not requiring manipulation)

Clinical Vignette:

An infant presenting with or without a hip click, abnormal buttocks creases and/or instability or with or without predisposing factors for developmental dysplasia of the hip.

Description of Physician Work Associated With This Procedure:

Pre-Service Physician Work:

- Review history and physical exam.

Intra-Service Physician Work:

- Obtain screening hip ultrasonic images from the coronal plane with measurements of the acetabular angle for documenting dysplasia and without manipulation.

Note: Patients with documented developmental dysplasia may be examined in a Pavlek harness or in or out of a cast without manipulation to assess the adequacy of reduction and/or treatment by verifying the relationship of the femoral heads to the acetabulum.

Post-Service Physician Work:

- Discuss results with patient's parents.
- Dictate, correct, and sign report.
- Discuss and communicate report/findings with referring physician(s).

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
FEBRUARY 1997

Sleep Studies- Tab 31

History and Review of Current Family of Sleep Study Services

In CPT 1994, code 95828 *Polysomnography; recording analysis and interpretation of the multiple physiological parameters of sleep* (work rvu = 2.79) was replaced with three new codes 95807, 95808, and 95810 to differentiate between the various levels of physician work involved in these services. The RUC recommended that the new relative values be budget neutral and, based on frequency data, provided the following recommendations: 95807 (1.70); 95808 (2.71); and 95810 (3.61). HCFA, after collecting frequency information for one year, agreed with the RUC recommendations.

The RUC reviewed and agrees with the appropriateness of the current relative for 95807, 95808, and 95810. These services have been reviewed by both the RUC and HCFA and were implemented in a budget neutral manner. In addition, the RUC was convinced that these services require a high level of technical skill. MDs providing these services are required to complete an additional year of fellowship training and an enormous amount of data must be reviewed.

New Code 95806

A new code 95806 was created to report a sleep study unattended by a sleep technologist. This service requires more physician work than the existing code 95807 *Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist* (1.66) because the physician interpretation will be more difficult without the observations and notes of the sleep technologist. The RUC agreed and recommends the survey median of 1.85 for 95806.

New Code 95811

After determining that CPT Code 95810 was appropriately valued, the RUC determined the appropriate increment between this service and the new code 95811 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist..*

HCFA has recommended that physicians report both 95810 (3.53) and 94660 (.76) when performing the service described by the new code 95811. The proposed work rvu for this new code (3.80) is less than the relative values of these two codes combined. The increment of .27 appears reasonable. The addition of CPAP requires a separate paragraph in the report which is critical for treatment decisions. This additional work is similar to code 71020 *Radiologic examination, chest, two views, frontal and lateral* (work rvu = .22) and code 93018 *Cardiovascular stress test, interpretation and report only* (work rvu = .30). The RUC recommends a work rvu of 3.80 for 95811.

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Sleep Studies Sleep studies and polysomnography refer to the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for 6 or more hours with physician review, interpretation and report. The studies are performed to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as nasal continuous positive airway pressure (NCPAP). Polysomnography is distinguished from sleep studies by the inclusion of sleep staging which is defined to include a 1-4 lead electroencephalogram (EEG), and electrooculogram (EOG), and a submental electromyogram (EMG). Additional parameters of sleep include: 1) EMG; 2) airflow; 3) ventilation and respiratory effort; 4) gas exchange by oximetry, transcutaneous monitoring, or end tidal gas analysis; 5) extremity muscle activity, motor activity movement; 6) extended EEG monitoring; 7) penile tumescence; 8) gastroesophageal reflux; 9) continuous blood pressure monitoring; 10) snoring; 11) body positions; ect. For a study to be reported as polysomnography, sleep must be recorded and staged. (Report with a -52 modifier if less than 6 hours of recording or in other cases of reduced services as appropriate) (For unattended sleep study/polysomnography, use 94799) (For unattended sleep study, use 95806)				
95805	E1	Multiple sleep latency testing (MSLT) , <u>or maintenance of wakefulness testing</u> , recording, analysis and interpretation of physiological measurements of sleep during multiple nap opportunities <u>trials to assess sleepiness</u>	XXX	1.88 (no change)
95807	E2	Sleep study, 3 or more parameters of sleep other than sleep staging , <u>simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation</u> , attended by a technologist	XXX	1.66 (no change)
•95806	E3	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist	XXX	1.85

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

CPT Code (• New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
95808		Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist	XXX	2.65 (no change)
95810		sleep staging with 4 or more additional parameters of sleep, attended by a technologist	XXX	3.53 (no change)
•95811	E4	sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist	XXX	3.80

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 9580X Tracking Number: E3 Global Period: XXX Recommended RVW: 1.85

CPT Descriptor:

Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

An elderly, inpatient female, noted by nursing staff to snore and stop breathing during sleep, undergoes a study in the inpatient unit, unattended by a technologist, using a portable recording device, with recording for 6 hours or more of airflow, respiratory effort, heart rate and oxygen saturation.

Description of Pre-Service Work:

Review of the pre-test consultation and data. Provide instruction to the technician who will be instructing the patient on how to get hooked up to the equipment. Provide instruction on use of drugs, including oxygen, by the patient during the day prior to the test and during the night of the test.

Description of Intra-Service Work:

Review the notes made by the technician who prepared the patient for the test. Opening the sleep record (hard copy or computer file). Analysis of the recording including identification and analysis of abnormal events in the recording. Differentiate artifacts from biological events.

Description of Post-Service Work:

Preparation of the report and communication of results to the patient and referring physician.

SURVEY DATA:

Specialty: American Sleep Disorders Association and the American Academy of Neurology

Sample Size: 150 Response Rate (%): 45 (30%) Median RVW: 1.85

25th Percentile RVW: 1.66 75th Percentile RVW: 2.54 Low: 0.95 High: 4.00

Median Pre-Service Time: 10 min. Median Intra-Service Time: 25 min.

25th Percentile Intra-Service Time: 15 min. 75th Percentile Intra-Service Time: 35 min.

Low Intra-Service Time: 0 min High Intra-Service Time: 60 min.

Median Post-Service Time: : 10 min.

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	95807	Sleep study, 3 or more parameters of sleep other than sleep staging, attended by a technologist	1.66
2)	95808	Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist	2.65

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The current sleep study code CPT 95807 (RVW - 1.66) was included as a reference service by 60% of the respondents as the primary reference service for this survey. The comparison of time and intensity of physician work to this reference service appears to support the rank order of 9580X and the recommended RVW of 1.85 for this new code.

As indicated in the table below, the median intra-service time and mean intensity estimates for 9580X are slightly higher than those for CPT 95807. The median pre- and post-service time for both codes were the same. Increased intra-service time and intensity figures reflect the added physician work involved to analyze and interpret the typically more complex recording (additional artifacts, etc.) and notes of a sleep study which was unattended by a technologist.

<u>Time Comparison (Medians)</u>	<u>9580X</u>	<u>95807</u>
Pre-Service	10 min	10 min
Intra -Service	25 min	20 min
Post-Service	10 min	10 min
<u>Intensity Comparison (Means)</u>	<u>9580X</u>	<u>95807</u>
Mental Effort & Judgment	3.56	3.36
Technical Skill & Physical Effort	3.38	3.28
Psychological Stress	2.98	2.64

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.
N/A - recommendation is based on survey results.

FREQUENCY INFORMATION

How was this service previously reported? CPT 94799

How often do physicians in your specialty perform this service? Commonly ☒ Sometimes ☐ Rarely ☐

Estimate the number of times this service might be provided nationally in a one-year period? Limited - exact estimate is not available.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 958XX Tracking Number: E4 Global Period: XXX Recommended RVW: 3.80

CPT Descriptor:

Polysomnography; sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

An elderly male with severe obstructive sleep apnea confirmed on previous testing, undergoes polysomnography, with recording of 6 or more hours of four-channel EEG, EOG and submental EMG for sleep staging, and ECG, airflow, respiratory effort and oximetry, while attended by a technologist who initiates Positive Airway Pressure treatment and titrates the inspiratory and expiratory pressures upwards using Continuous or Bi-level Positive Airway pressure in order to control the abnormal respiratory events during sleep.

Description of Pre-Service Work:

Review of the pre-test consultation and data. Provide instruction to the night technician who will be hooking up the patient to the equipment, including starting pressures, sequence of pressures tested and the use of BiPAP. Provide instruction on use of drugs, including oxygen, by the patient during the day prior to the test and during the night of the test.

Description of Intra-Service Work:

Review of the sleep technician's notes. Opening the sleep record (hard copy or computer file). Analysis of the recording including identification and analysis of abnormal events in the recording and compiling abnormal events separately for each CPAP pressure used.

Description of Post-Service Work:

Preparation of the report and communication of results to the patient and referring physician.

SURVEY DATA:

Specialty: American Sleep Disorders Association and the American Academy of Neurology

Sample Size: 150 Response Rate (%): 45 (30%) Median RVW: 3.80

25th Percentile RVW: 3.53 75th Percentile RVW: 4.20 Low: 0.87 High: 5.30

Median Pre-Service Time: 15 min. Median Intra-Service Time: 35 min.

25th Percentile Intra-Service Time: 20 min. 75th Percentile Intra-Service Time: 45 min.

Low Intra-Service Time: 0 min. High Intra-Service Time: 120 min.

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	95810	Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist	3.53
2)	95808	Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist	2.65

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The current polysomnography code CPT 95810 (RVW - 3.53) was included as a reference service by nearly 85% of the respondents for this survey. The comparison of time and intensity of physician work to this reference service appears to support the rank order of 958XX and the recommended RVW of 3.80 for this new code.

As indicated in the table below, the median time and mean intensity estimates for 958XX are generally slightly higher than those for CPT 95810. The median intra-service time for both codes were the same. Increased time and intensity figures reflect the added physician work involved when nasal continuous positive airway pressure (NCPAP) therapy is performed in addition to the polysomnography sleep staging involving 4 or more additional parameters of sleep.

<u>Time Comparison (Medians)</u>	<u>958XX</u>	<u>95810</u>
Pre-Service	15 min	10 min
Intra -Service	35 min	35 min
Post-Service	20 min	10 min
<u>Intensity Comparison (Means)</u>	<u>958XX</u>	<u>95810</u>
Mental Effort & Judgment	4.31	3.94
Technical Skill & Physical Effort	4.20	3.81
Psychological Stress	3.62	3.03

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

N/A - recommendation is based on survey results.

FREQUENCY INFORMATION

How was this service previously reported? CPT 95810 and CPT 94660

How often do physicians in your specialty perform this service? X Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 30 - 45,000

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Hysterosonography - Tab 11

76831, *Hysterosonography, with or without color flow Doppler*, is a new code used to determine the presence of endometrial abnormalities such as hyperplasia, submucosal endometrial fibroids or carcinoma. Prior to imaging, a catheter is placed into the endometrial cavity and saline is injected. These services are reported using code 58340, *Catheterization and introduction of saline or contrast material for hysterosonography or hysterosalpingography*, which is separately reportable. Code 76831 was surveyed by two specialty societies with median RVUs of 0.92 and 0.78. Also, 76831 can be compared to the transvaginal ultrasound, 76830, *Echography, transvaginal* (RVU=0.69), plus 0.03 RVUs for the color Doppler. Color Doppler in echocardiography (code 93325) is equivalent to 0.07 RVUs. Based on the comparison to 76830 and 93325, the RUC recommends that 76831 should be valued at 0.72 work RVUs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•76831	GG1	Hysterosonography, with or without color flow Doppler (For procedure, see 58340) (For introduction of saline for hysterosonography, see 58340)	XXX	0.72
58340	GG2	Catheterization and introduction of saline or contrast material Injection procedure for <u>hysterosonography</u> or hysterosalpingography (For radiological supervision and interpretation of hysterosonography, see 76831) (For radiologic supervision and interpretation of <u>hysterosalpinography</u> , see 74740)	XXX	0.88 (no change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION
American College of Radiology
American College of Obstetricians and Gynecologists

CPT Code: 7683X Tracking Number: GG1 Global Period: XXX Recommended RVW: 0.72

CPT Descriptor: Hysterosonography, with or without color flow Doppler

CLINICAL DESCRIPTION OF SERVICE:

Vignettes Used in Survey:

Clinical Vignette 1:

A fifty-six year old female presents with post-menopausal bleeding. Previous transvaginal ultrasound demonstrates endometrial thickening of more than 5mm. A hysterosonogram is performed to determine the presence of endometrial abnormalities (e.g. hyperplasia, polyps, submucosal endometrial fibroids, carcinoma).

Clinical Vignette 2:

A twenty-nine year old female infertility patient undergoes hysterosonography for assessment of tubal patency.

Description of Physician Work Associated With This Procedure:

Pre-Service Physician Work:

- Review prior studies and patient history for appropriateness

Intra-Service Physician Work:

- Insert transvaginal ultrasound probe
- Visualize and thoroughly examine the endometrial cavity under ultrasound
- Interpret sagittal, coronal, and (if performed) color Doppler images

**Prior to imaging, a catheter is placed into the endometrial cavity and saline is injected. These services are contained under code 58340 which is separately reportable.*

Post-Service Physician Work:

- Communicate findings to referring/primary care physician
 - Dictate written report
-

SURVEY DATA:Specialty: American College of RadiologySample Size: 32 Response Rate (%): N = 16 (50%) Median RVW: 0.9225th Percentile RVW: 0.72 75th Percentile RVW: 1.07 Lowest RVW: 0.54 Highest RVW: 1.80Median Total Service Time: 25 minutes25th Percentile Total Service Time: 20 minutes75th Percentile Total Service Time: 32 minutesLowest Total Service Time: 10 minutesHighest Total Service Time: 45 minutes

Specialty: American College of Obstetricians and GynecologistsSample Size: 77 Response Rate (%): 16% (N = 12) Median RVW: 0.7825th Percentile RVW: 0.74 75th Percentile RVW: 0.99 Lowest RVW: 0.50 Highest RVW: 2.10Median Pre-Service Time: 15 minutes Median Intra-Service Time: 20 minutes25th Percentile Intra-Service Time: 15 minutes75th Percentile Intra-Service Time: 20 minutesLowest Intra-Service Time: 8 minutesHighest Intra-Service Time: 35 minutesMedian Post-Service Time: 10 minutes

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>(1997) RVW</u>	<u>Societies</u>
1) 76805	Echography, pregnant uterus, B-scan and/or real time with image documentation complete (complete maternal and fetal evaluation)	0.99	ACOG
2) 74740	Hysterosalpingography, radiological supervision and interpretation	0.38	ACR
3) 76830	Echography, transvaginal	0.69	ACR/ACOG
4) 76856	Echography, pelvic (non-obstetric), B-scan, and/or real time with image documentation, complete	0.69	ACOG

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

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Total Time		Median Mental Effort & Judgment		Median Technical Skill & Physical Effort		Median Psychological Stress	
	ACR	ACOG	ACR	ACOG	ACR	ACOG	ACR	ACOG
7683X	25	45	3	3	4	4	3	3
76805	NA	37.5	NA	4	NA	35	NA	2.5
76830	22	32	3	3	3	3	3	2
76856	NA	40	NA	3	NA	3	NA	2.5
74740	15	NA	3	NA	3	NA	3	NA

	ACR	ACOG
Number of times performed in last 12 months (median)	15	10
Agree with vignette?	Yes (93%, N=13) No (71%, N=1)	Yes (92%, N=11) No (8%, N=1)

ADDITIONAL RATIONALE

The recommended RVW for Hysterosonography (code 7683X) is based on transvaginal ultrasound (code 76830; RVW of 0.69) plus 0.03 RVUs for color doppler. [Color doppler for echocardiography (code 93325) has a RVW of 0.07.]

FREQUENCY INFORMATION

How was this service previously reported? 76830 or 76999

How often do physicians in your specialty perform this service?

Commonly X Sometimes Rarely

Estimate the number of times this service might be performed nationally
in a one-year period? unable to quantify

Is this service performed by many physicians across the United States? Yes X No

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Radical Trachelectomy - Tab 12

CPT code 57531, *Radical trachelectomy with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)*, is a new code used for the removal of the cervix and upper one third of the vagina. This service is similar to code 58210, *Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)* (RVU=27.00), except that the new code describes an operation to remove the cervical stump which was left intact during a subtotal hysterectomy. The fact that the fundus of the uterus is not present and that the cervix is heavily scarred and inflamed, makes 57531 more difficult than 58210. Survey data from 29 obstetricians and gynecologists show a median RVU of 28.00 and a median intra-service time of 240 minutes. For code 57531 the RUC recommends the survey median, 28.00 work RVUs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•57531	YY1	Radical trachelectomy with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)	090	28.00

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

CPT Code: 5753X Tracking Number: YY1 Global Period: 090 Recommended RVW: 28.00

CPT Descriptor: Radical trachelectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 59-year old woman who underwent a prior subtotal hysterectomy for severe pelvic endometriosis at age 40 presented with a friable exophytic lesion on the cervix, which on biopsy is an invasive squamous cell carcinoma. Clinical assessment and staging revealed this to be a stage Ib cancer of the cervical stump. The patient now undergoes a radical excision of cervical stump with a bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling. After discharge from the hospital, she receives office follow-up care during the 90 day global period.

Description of Pre-Service Work: Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status. Indications for the procedure and its appropriateness are reviewed. Informed consent is obtained. The physician will admit the patient to the hospital, prepare the hospital records and chart in accordance with hospital policy, will check on the patient, and will review records prior to the surgery. The physician then scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient.

Description of Intra-Service Work:

The patient is examined under anesthesia to assess operability. An incision is made and carried by layers until the peritoneal cavity is entered. An exploration of the abdominal and pelvic cavities is performed. The cervix and upper 1/3 of the vagina are excised. removed by dissecting the ureter from the parametria and tunnel and by cutting, clamping and suturing vascular and supporting pedicles. A radical bilateral pelvic lymphadenectomy is performed either prior to or immediately following the radical excision of the cervix. The pelvic lymphadenectomy skeletonizes the common external, hypogastric and obturator vessels. A selected para-aortic lymph node sampling is performed. The peritoneal cavity is irrigated. Closed suction drains may be used. Local anesthesia is administered when indicated. The abdomen is closed in layers. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work: Post-service work begins in the operating room after skin closure with the application of sterile dressings. Post-service work includes monitoring the patient's stability in the recovery room; communicating with the family and other health care professionals (including written and oral reports and orders); ordering and reviewing of post-operative radiographs and laboratory studies; careful attention to fluid-volume and electrolyte status; monitoring and care of the incision; monitoring, maintaining, and removing all tubes, drains, and catheters; antibiotic and pain medication management; and all other hospital visits and services performed by the surgeon. A patient undergoing radical trachelectomy usually spends two days in the intensive care unit and is discharged on the seventh post-operative day. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge visits for this procedure for 90 days after the day of the operation are considered part of the post-service work (the patient is typically seen in the office 3 times), including removal of sutures; ordering and evaluating periodic imaging and laboratory studies, if needed; obtaining and reviewing all final surgical histopathology results; further coordination of care with a referring physician, and antibiotic and pain medication adjustments.

SURVEY DATA:Specialty: ACOGSample Size: 112 Response Rate (%): 29 (26%) Median RVW: 28.0025th Percentile RVW: 27.00 75th Percentile RVW: 29.00 Low: 27.00 High: 30.00Median Pre-Service Time: 70 minutes Median Intra-Service Time: 240 minutes25th Percentile Intra-Svc Time: 210 min. 75th Percentile Intra-Svc Time: 300 min. Low: 50 High: 480

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	
ICU:	<u>40</u>	<u>2</u>
Other Hospital:	<u>100</u>	<u>5</u>
Office:	<u>3</u>	<u>60</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	58210	Radical abdominal hysterectomy	27.00
2)	55845	Prostatectomy, retropubic radical....	26.73
3)	58150	Total abdominal hysterectomy	14.30
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Pre- and post-service work for 5753X is very similar to that for 58210. Intra-service work is also similar to that for a radical hysterectomy. There are 3 important variations, however: because the fundus of the uterus is not present, it is difficult to gain traction on the operative specimen which is so important in identifying the necessary tissue plane to perform this operation; typically, a cervical stump is present because of extensive scarring or inflammation which necessitated the prior subtotal hysterectomy rather than the standard total hysterectomy. Accordingly, the typical patient with a cervical stump also has extensive pelvic adhesions which increase the risk of complications and increase the intra-service work time. Typically, with a residual cervical stump, it is technically much more difficult to develop a plane between the bladder and cervix as well as a plane between the rectum and posterior vagina. Therefore, the committee felt the survey median of 28.00 RVUs, slightly higher than the RVUs for 58210 was appropriate.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
5753X	70	240	30	4	5	4.5
58210	70	240	30	4	5	4
55845	60	210	30	5	5	5
58150	65	90	35	2.5	2.5	2

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

Pre-Service	99223	2.99
Intra-service	240 min. X .075 RVUs per minute*	18.00
Post-Service	99233 x 2	3.02
	99232 x 1	1.06
	99231 x 3	1.92
	99238	1.28
	99214	1.1
	99213 x 2	1.34
		<hr/> 30.71

* 0.075 RVUs per minute is the intra-service work per unit time (IWPUT) of an exploratory laparotomy (49000). ACOG used this level of IWPUT to validate survey results for abdominal surgical procedures in the five year review.

FREQUENCY INFORMATION

How was this service previously reported? 57530-22

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not available

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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Removal of Cerclage Suture - Tab 13

CPT code 59871, *Removal of cerclage suture under anesthesia (other than local)*, is a new code which describes the work involved in removing a cervical suture under anesthesia. 59871 can be compared to 59320, *Cerclage of cervix, during pregnancy; vaginal* (RVU=2.48), except that 59871 requires less intra-service time and lower levels of judgment, technical skill and stress. Survey data for 5987X show a median RVU of 2.13 and a median intra-service time of 20 minutes. The RUC recommends the survey median, 2.13 work RVUs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
59871	ZZ1	Removal of cerclage suture under anesthesia (other than local)	000	2.13

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

CPT Code: 5987X Tracking Number: ZZ1 Global Period: 000 Recommended RVW: 2.13

CPT Descriptor: Removal of cerclage suture under anesthesia (other than local)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A pregnant patient at 37 weeks gestation presented for removal of a Shirodkar cerclage that was placed at 14 weeks gestation. The suture was to be removed prior to the onset of labor because she has attained fetal lung maturity and a vaginal delivery is desired. The suture knot of the cerclage was buried beneath the cervical-vaginal mucosa or the cervical mucosa posteriorly and the knot or suture was not readily able to be removed under local anesthetic. The patient is now taken to the operating room for removal of the cerclage under anesthesia. A weighted speculum is placed into the vagina and a retractor is manually held anteriorly to expose the entire cervix which is distorted from the cerclage. A small incision is made over the knot which is buried beneath the mucosa. The suture is elevated and the knot is cut allowing the suture to be pulled and withdrawn from the cervix. The mucosa is then reapproximated with absorbable suture. The patient is taken to the recovery room and observed for bleeding and uterine contractions.

Pre-service work: Counseling the patient about the possible immediate onset of labor, performance of admission history and physical, monitoring fetal activity prior to starting the procedure.

Intra-service work: Placement of a weighted speculum in the vagina. Exposure of cervix with a retractor. Incision is made over the knot which is buried beneath the mucosa. The suture is elevated and the knot is cut allowing the suture to be pulled and withdrawn from the cervix. The mucosa is then reapproximated with absorbable suture.

Post-service work: Dictate report, monitor patient for bleeding and onset of contractions until either the onset of labor or it is deemed safe to discharge the patient home. Give patient instructions about the onset of labor returning immediately upon the rupture of membranes or the onset of contractions (if discharged home).

SURVEY DATA:

Specialty: ACOG

Sample Size: 77 Response Rate (%): 13 (17%) Median RVW: 2.13

25th Percentile RVW: 2.00 75th Percentile RVW: 2.25 Low: 1.50 High: 3.00

Median Pre-Service Time: 27.5 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 20 Low: 10 High: 40

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 15

ICU: _____

Other Hospital: _____

Other Hospital: _____

Office: _____

CPT Code: 5987X

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	59320	Cerclage of cervix, during pregnancy; vaginal	2.48
2)	57410	Pelvic examination under anesthesia	1.75
3)	58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	2.91
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

5987X requires less intra-service time and lower levels of judgment, technical skill, and stress than 59320. Therefore, the survey mean seemed appropriate

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
5987X	27.5	20	15	2	3	2
59320	30	30	15	4	4	4
57410	25	10	10	2	2	2
58120	20	25	10	3	3	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

Pre-Service	99221	1.28
Intra-Service	0.03 RVUs per min x 20 min	0.60
Post-Service	99238	1.28
		3.16

FREQUENCY INFORMATION

How was this service previously reported? 59999

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

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

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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Repair of Non-Structural Valve Dysfunction - Tab 14

CPT code 33496, *Repair of non-structural prosthetic valve dysfunction with cardiopulmonary bypass (separate procedure)*, is a new code which describes the work involved in repairing a leak in a prosthetic valve which was installed previously. In its review the RUC discussed how the work involved in this code compares to 33405, *Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft* (RVU=28.47). They concluded that the new code has many of the same difficulties which are associated with 33405 such as; entering the chest again and working with scar tissue. Because of these issues, the RUC recommends that the value of 33530, *Reoperation, coronary artery bypass procedure or valve procedure, more than one month after original operation (list separately in addition to code for primary procedure)* (RVU=5.86), be subtracted from the specialty recommended value and that 33496 be added to the group of codes which may be reported with 33530. The specialty recommendation is based on survey data which show a median RVU of 31.50. The calculation is as follows $31.50 - 5.86 = 25.64$. Thus, the RUC recommends a value of 25.64 work RVUs for 33496.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•33496	BB1	Repair of non-structural prosthetic vavle dysfunction with cardiopulmonary bypass (separate procedure) (For reoperation, use 33530 in addition to 33496)	090	25.64

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

CPT Code: 3349X Tracking Number: BB1 Global Period: 090 Recommended RVW: 31.5

CLINICAL DESCRIPTION OF SERVICE

CPT Code Descriptor: Repair of non-structural prosthetic valve dysfunction with cardiopulmonary bypass (separate procedure)

Vignette Used in Survey:

A 58-year-old man, status post bileaflet mechanical prosthetic aortic valve replacement 9 months previous, was seen in the office with evidence of congestive heart failure secondary to aortic insufficiency. Laboratory studies revealed anemia secondary to hemolysis; there was no evidence for bacterial endocarditis. Cardiac catheterization studies were reviewed, and these revealed 4+ aortic insufficiency. A transesophageal echocardiogram revealed dehiscence of the valve in the area of the noncoronary cusp with motion of the prosthetic valve ring.

Description of preservice work.

The patient was admitted and the surgeon visited him the day before the operation to perform a preoperative physical examination (history and physical), review the risks and benefits of the procedure with the patient and his family, verify informed consent, Laboratory and imaging studies were also reviewed.

Description of intraservice work.

After general endotracheal anesthesia, a redo sternotomy was performed, the surgeon identified scarring, multiple adhesions, and friable tissue, which were carefully dissected out. The patient was placed on cardiopulmonary bypass, the aorta was cross-clamped and aortotomy performed. Exposure of the aortic root revealed that the sutures had pulled through the annulus in the area of the noncoronary cusp. A series of mattress sutures were placed from outside the ascending aortic wall through the prosthetic valve sewing ring. The sutures were tied into place and the perivalvular area inspected for possible perivalvular leaks. The aortotomy was closed, the aortic cross-clamp removed, and air was evacuated from the left side of the heart. The patient was weaned from cardiopulmonary bypass. The surgeon spent the next 45 minutes attempting to achieve hemostasis. When this was completed, chest tubes were inserted, the sternum was reclosed, and the patient was sent to the surgical intensive care unit.

Description of postoperative work.

During the first six postoperative hours the surgeon remained at the patient's bedside in the ICU to monitor the substantial chest tube output. The surgeon also monitored the patient using a transesophageal echocardiogram for potential pericardial tamponade and the consequent necessity of a return to the operating room. The surgeon treated the patient with blood component therapy and over the next 3 hours bleeding from the chest tube gradually diminished. The patient was seen again that evening. The surgeon visited the patient twice on Days 1 and 2 postoperatively to conduct a physical examination and review vital signs, tests, and laboratory studies. In-hospital visits were conducted daily on Postoperative Days 3-7, and the patient was discharged home on Postoperative Day 7. Two postdischarge office visits were conducted, one 3 weeks following surgery where physical examination was conducted and wound care given and one two months after surgery, where it was confirmed that the patient's 4+ aortic insufficiency had resolved and that the prosthetic valve was functioning normally.

SURVEY DATA:

Specialty: Society of Thoracic Surgeons/American Association for Thoracic Surgery

Sample Size: 49 Response Rate (%): 30 (61%) Median RVW: 31.5

25th Percentile RVW: 30 75th Percentile RVW: 34 Low: 26.2 High: 36.5

Median Pre-Service Time: 60 min Median Intra-Service Time: 300 min

25th Percentile Intra-Svc Time: 240 min 75th Percentile Intra-Svc Time: 350 min Low: 60 min High: 480 min

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 180 min

ICU: 80 min 4

Other Hospital: 75 min 4

Office: 60 min 2

CPT Code: 3349X

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	33405	Aortic valve replacement, w/cardiopulmonary bypass	28.47
2)	33411	Aortic valve replacement, w/aortic annulus enlargement	30.37
3)	33430	Mitral valve replacement	29.42
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
33405	60 min	240 min	60 min	4	4	4
33411	60 min	210 min	30 min	4	4	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? 33999 or not reported

How often do physicians in your specialty perform this service? Commonly Sometimes X Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 200-250

Is this service performed by many physicians across the United States? Yes X No

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Psychotherapy - Tab.15

Twenty-four new psychotherapy codes have been crosswalked from the G0071-G0094 HCPCS Level II codes developed by HCFA. The current HCPCS Level II codes have work RVUs assigned to them by HCFA. The RUC extensively discussed this issue and was concerned that survey data on these new codes were not available for all providers. The RUC recommends that the current G-code values be crosswalked to the CPT codes and remain interim until the RUC can revisit the issue after a survey has been conducted by each of the professions providing these services, including psychiatry, psychology, social work, and nursing.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Psychiatry</p> <p>Hospital care by the attending physician in treating a psychiatric inpatient or partial hospitalization may be initial or subsequent in nature (see 99221-99233) and may include exchanges with nursing and ancillary personnel. Hospital care services involve a variety of responsibilities unique to the medical management of inpatients, such as physician hospital orders, interpretation of laboratory or other medical diagnostic studies and observations, review of activity therapy reports, supervision of nursing and ancillary personnel, and the programming of all hospital resources for diagnosis and treatment.</p> <p>When services include not only a visit to the patient, but also activity in leadership or direction of a treatment team as related to that patient, a code may be selected based upon the services provided that day.</p> <p>Some patients receive hospital evaluation and management services only and others receive evaluation and management services and other procedures. If other procedures such as electroconvulsive therapy or medical psychotherapy are rendered in addition to hospital evaluation and management services, these should be listed separately (ie, hospital care service plus electroconvulsive therapy or plus medical psychotherapy if rendered when <u>psychotherapy is done, an appropriate code designating psychotherapy with medical evaluation and management services</u>).</p>				

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Psychiatric care may be reported without time dimensions according to the procedure or service as are other medical or surgical procedures.</p> <p>In reporting medical psychotherapy procedures, time is only one aspect and may be expressed as is customary in the local area. For example, the usual appointment length of an individual medical psychotherapy procedure may be signified by the procedure code alone. <u>The modifier '-22' or 09922 may be used to indicate a more extensive service.</u> The modifier '-52' or 09952 may be used to signify a service that is reduced or less extensive than the usual procedure. The modifier '-22' or 09922 may be used to indicate a more extensive service.</p> <p>Thus, medical psychotherapy procedures may be reported by the procedure code alone or by the procedure code with a modifier.</p> <p>If appropriate and customary in the local area, codes 90841, 90842, 90843 or 90844 may be used.</p> <p>Other evaluation and management services, such as office medical service or other patient encounters, may be described as listed in the section on Evaluation and Management, if appropriate.</p> <p><u>The Evaluation and Managment services should not be reported separately, when reporting codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829).</u></p> <p><u>Consultation for psychiatric evaluation of a patient includes examination of a patient and exchange of information with the primary physician and other informants such as nurses or family members, and preparation of a report. These consultation services (99241-99263) are limited to initial or follow-up evaluation and do not involve psychiatric treament.</u></p> <p>General Clinical Psychiatric Diagnostic or Evaluative Interview Procedures</p> <p><u>Psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances other informants will be seen in lieu of the patient.</u></p>				
90801	RR1	Psychiatric diagnostic interview examination including history, mental status, or disposition (may include communication with family or other	XXX	2.80

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<p>sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances other informants will be seen in lieu of the patient).</p> <p>Consultation for psychiatric evaluation of a patient includes examination of a patient and exchange of information with primary physician and other informants such as nurses or family members, and preparation of report. These consultation services (99241-99263) are limited to initial or follow up evaluation and do not involve psychiatric treatment. For treatment, see 99221 et seq or 90841 et seq.</p>		
90802	RR2	<p>Interactive psychiatric diagnostic interview examination using play equipment , physical devices, or other mechanisms of communication</p> <p>Special Clinical Psychiatric Diagnostic Or Evaluative Procedures</p> <p>Interactive procedures (90820) 90802 are distinct forms of diagnostic procedures which predominantly use physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the physician and a patient who has lost, or has not yet developed either the expressive language communication skills to explain his/her symptoms and response to treatment.....</p>	XXX	3.01
<p>Psychiatric Therapeutic Procedures</p> <p>Interactive procedures (90855, 90857) are distinct medical psychotherapeutic procedures which predominantly use physical aids and nonverbal communication to overcome barriers to therapeutic interaction between the physician and a patient who has lost, or has not yet developed either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the physician if he/she were to use ordinary adult language for communication.</p>				

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p><u>Psychotherapy is the treatment for mental illness and behavioral disturbances in which the therapist establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. The codes for reporting psychotherapy are divided into two broad categories: Interactive Psychotherapy; and Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy.</u></p> <p><u>Interactive psychotherapy is typically furnished to children. It involves the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the physician and a patient who has lost, or has not yet developed, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the physician if he/she were to use ordinary adult language for communication.</u></p> <p><u>Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change.</u></p> <p><u>Some patients receive psychotherapy only and others receive psychotherapy and medical evaluation and management services. These evaluation and management services involve a variety of responsibilities unique to the medical management of psychiatric patients, such as medical diagnostic evaluation, drug management when indicated, physician orders, interpretation of laboratory or other medical diagnostic studies and observations.</u></p> <p><u>In reporting psychotherapy, the appropriate code is chosen on the basis of the type of psychotherapy (interactive using non-verbal techniques versus insight oriented, behavior modifying and/or supportive using verbal techniques), the place of service (office versus inpatient), the face-to-face time spent with the patient during psychotherapy, and whether evaluation and management services are furnished on the same date of service as psychotherapy.</u></p> <p><u>To report medical evaluation and management services furnished on a day when psychotherapy is not provided, providers select the appropriate code from the Evaluation and Management Services Guidelines.</u></p> <p><u>Office or Other Outpatient Facility</u></p> <p><u>Insight oriented, behavior modifying and/or supportive psychotherapy</u></p>				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•90804	RR3	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;	XXX	1.11
•90805	RR4	with medical evaluation and management services	XXX	1.47
•90806	RR5	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;	XXX	1.72
•90807	RR6	with medical evaluation and management services	XXX	2.00
•90808	RR7	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face- to-face with the patient;	XXX	2.76
•90809	RR8	with medical evaluation and management services	XXX	3.15
•90810	RR9	Individual psychotherapy, interactive, using play equipment, physical devices, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;	XXX	1.19
•90811	RR10	with medical evaluation and management services	XXX	1.58
•90812	RR11	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;	XXX	1.86
•90813	RR12	with medical evaluation and management services	XXX	2.15

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•90814	RR13	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;	XXX	2.97
•90815	RR14	with medical evaluation and management services	XXX	3.39
•90816	RR15	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospitalization or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;	XXX	1.24
•90817	RR16	with medical evaluation and management services	XXX	1.65
•90818	RR17	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospitalization or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;	XXX	1.94
•90819	RR18	with medical evaluation and management services (90820 has been deleted, To report, use 90802)	XXX	2.24
•90821	RR19	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospitalization or residential care setting, approximately 75 to 80 minutes face-to-face with the patient	XXX	3.09
•90822	RR20	with medical evaluation and management services	XXX	3.53
•90823	RR21	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to face with the patient;	XXX	1.33
•90824	RR22	with medical evaluation and management services	XXX	1.77

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•90825		Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes.	XXX	
•90826	RR23	Individual psychotherapy, interactive, using play equipment, physical devices, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;	XXX	2.08
•90827	RR24	with medical evaluation and management services	XXX	2.41
•90828	RR25	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to face with the patient;-	XXX	3.32
90829	RR26	with medical evaluation and management services (90830) has been deleted. To report, use 96100) (90831) has been deleted. To report see 99371-99373)	XXX	3.80
90835	RR27	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (eg, sodium amobarbital - (Amytal interview) (90835 has been deleted. To report, see 90865)		NA
90841	RR28	Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated, including insight oriented, behavior modifying or supportive psychotherapy (face to face with the patient); time unspecified (90841 has been deleted.)	XXX	NA
90842	RR29	approximately 75 to 80 minutes (90842 has been deleted. To report, see 90808, 90809, 90820, 90821) 90822	XXX	NA

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
90843	RR30	approximately 20 to 30 minutes (90843 has been deleted. To report, see 90804, 90805, 90806, 90807)	XXX	NA
90844	RR31	approximately 45 to 50 minutes (90844 has been deleted. To report, see 90806, 90807, 90818, 90819)	XXX	NA
90845	RR32	Medical Psychoanalysis	XXX	1.79 (no change)
90846	RR33	Family Medical psychotherapy (without the patient present)	XXX	1.83 (no change)
90847	RR33	Family Medical psychotherapy (conjoint psycho-therapy) by a physician, with continuing medical diagnostic evaluation, and drug management when indicated	XXX	2.21 (no change)
90849	RR34	Multiple-family group medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated	XXX	0.59 (no change)
90853	RR35	Group medical psychotherapy (other than of a multiple-family group) by a physician, with continuing medical diagnostic evaluation, and drug management when indicated	XXX	0.59 (no change)
90855	RR36	Interactive individual medical psychotherapy (90855, has been deleted. To report, see 90810-90815, and 90822-90827)	XXX	NA
90875	RR37	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy, (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	XXX	1.20 (See HCPAC recommendation)

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
90876	RR38	approximately 45-50 minutes	XXX	1.90 (See HCPAC Recommendation)
90880	RR39	Medical H ypnotherapy	XXX	2.19 (no change)

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Conscious Sedation - Tab 16

The RUC considered two new CPT codes for conscious sedation; 99141, *Sedation with or without analgesia (conscious sedation); intravenous, intramuscular or inhalation*, and 99142, *...oral, rectal and/or intranasal*. The RUC agreed that conscious sedation represents the lowest end of the spectrum of anesthesia services and the only comparable codes would be anesthesia codes. However, the intra service portion for the sedation alone is not as intense as an anesthesia service because the physician's attention is devoted to the principal procedure and the pre and post work for conscious sedation is more similar to an evaluation and management service.

The RUC chose to evaluate 99141 and 99142 by assigning what was believed to be appropriate intra-service work per-unit of time (IWPUT) for the pre-, intra-, and post-service periods. When reviewing intra-service work, the RUC recommends 50% of the accepted anesthesia intra-work intensity, $.5(.017) = .0085$, and 20 minutes of intra-service work. Half of the anesthesia work intensity was selected because physicians do not spend all their time and effort on anesthesia, in that they are involved with the primary service. Twenty minutes of intra-service time is supported by the pediatric survey data and adequately distinguishes the provision of sedation from the primary procedure.

For both pre and post-service work the RUC recommends assigning an IWPUT equivalent to an evaluation and management service (0.027) and assuming 10 minutes for both pre and post time. The RUC arrived at 10 minutes of work because it is supported in the survey data which show median time in excess of 10 minutes and because it was felt that some of the pre and post-work for the primary service overlaps with work for conscious sedation. It was expressed that the survey results of 1.80 and 2.40 did not recognize the overlap of time with the primary procedure.

The resulting calculation is: $10(.027) + 20(.0085) + 10(.027) = 0.71$ RVUs. The RUC viewed the value of 0.71 RVUs as a middle range. The value was adjusted up for 99141 to 0.80 and down for 99142 to 0.60. This adjustment compensated for the varying levels of difficulty associated with the two routes for administration of the sedation.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Anesthesia Guidelines <i>(to become last paragraph, page 41, CPT '97)</i> <u>To report sedation with or without analgesia (conscious sedation) provided by a physician also performing the service for which conscious sedation is being provided, see codes 99141, 99142.</u> <u>To report regional or general anesthesia provided by a physician also performing the services for which the anesthesia is being provided, see modifier '47, Anesthesia by Surgeon, in Appendix</u> <u>Sedation With or Without Analgesia (Conscious Sedation)</u> <u>Sedation with or without analgesia (conscious sedation) is used to achieve a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and ability to respond to stimulation or verbal commands. Conscious sedation includes performance and observation of pre-and post-sedation evaluations of the patient, administration of the sedation and/or analgesia agent(s), and monitoring of cardiorespiratory function (ie, pulse oximetry, cardiorespiratory monitor, and blood pressure. The use of these codes requires the presence of an independent trained observer to assist the physician in monitoring the patient's level of consciousness and physiological status.</u> <u>(If the sedation with or without analgesia (conscious sedation) is administered in support of a procedure provided by another physician, see Anesthesia section)</u>				
•99141	NN1	Sedation with or without analgesia (conscious sedation); intravenous, intramuscular or inhalation <u>(94760-94762 may not be reported in addition to 99141)</u>	XXX	0.80
•99142	NN2	oral, rectal and/or intranasal <u>(94760-94762 may not be reported in addition to 99142)</u>	XXX	0.60

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 991X1 Tracking Number: NN1 Global Period: XXX Recommended RVW: 2.45

CPT Descriptor:

Sedation with or without analgesia (conscious sedation);
intravenous, intramuscular or inhalation

(94760-94762 may not be reported in addition to 991X1)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A nine year old child presents to the Emergency Department with a closed distal radius and ulna fracture sustained from a rollerblading accident. Radiographs reveal that the portions of the ulna and radius distal to the fracture are somewhat displaced and will require closed reduction prior to splinting or casting. This very anxious child will clearly not tolerate this relatively brief though rather painful procedure. It is clear to the physician that an acceptable reduction will only be accomplished with the use of sedation and analgesia. The patient is administered intravenous doses of fentanyl and midazolam

*The physician work related to the repair of the fracture **SHOULD NOT** be included in your determination of work for this procedure (administration of sedation and analgesia).*

*The work performed by this independent observer **SHOULD NOT** be included in your determination of physician work.*

Description of Pre-Service Work:

The physician must first perform and document a complete screening examination for sedation and analgesia. This includes a fairly detailed history including the specifics of the current injury, current medications, medication allergies, immunization status, prior injuries and illness and any prior anesthetic experience. The timing and content of the patient's last meal is also of paramount importance. The child then requires a fairly detailed physical examination. This is directed to assess the patient's stability or suitability for sedation and analgesia, and to rule out any underlying pathology which could be masked by the sedation and analgesia.

Once this screening examination is completed, and providing the patient is determined to be an acceptable candidate for sedation and analgesia, informed consent must then be obtained from the child's parents and documented. This will include a detailed description of the need for sedation and the inherent risks and benefits. The physician will likely discuss the various available or acceptable agents and which agent(s) he or she is recommending for this patient.

Upon obtaining informed consent, the patient is then prepared for the procedure. The physician must calculate, recheck and document the appropriate medication dosage(s). The child must then be placed on cardiorespiratory monitoring including dynamic EKG and pulse oximetry, and intermittent dynamap blood pressure monitoring. Appropriate equipment to maintain an intact airway and ventilation, if needed, must also be mobilized (i.e., suction apparatus, bag and mask, reversal agents).

Description of Intra-Service Work:

The intra-service period will vary depending upon the desired level and length of sedation and analgesia and the agent(s) and route of administration determined to be the most appropriate for the patient and service. If the patient is administered intravenous doses of fentanyl and midazolam (991X1), this will require the placement of an intravenous catheter. Upon completion of drug administration, the patient remains monitored and under observation until an acceptable level of sedation has been achieved. The length of this pre-sedation period may vary depending upon the agent, route and dose, and characteristics of the patient. If acceptable levels of sedation and analgesia are not achieved, the child may require the administration of additional doses of medication.

Description of Post-Service Work:

Once the physician has assessed and documented that adequate sedation is achieved, the physician then proceeds with the procedure. The patient is carefully monitored throughout the procedure by an independent observer who has the appropriate training and skills required to assess the patient's vital signs, oxygenation, patient's level of sedation and comfort, and to assist the physician with the management of associated complications. Upon completion of the procedure, the patient is then monitored by the observer and the physician until the child has reached her pre-sedation level of consciousness. The physician then conducts and documents a clinical assessment regarding whether the child has reached discharge criteria. If so, monitoring is terminated and the patient is discharged to home.

SURVEY DATA:

Specialty: American Academy of Pediatrics (AAP)- see additional rationale section

Sample Size: n=380 Response Rate (%): 24% (91) Median RVW: 1.80

25th Percentile RVW: 1.40 75th Percentile RVW: 2.45 Low: 0.60 High: 4.20

Median Pre-Service Time: 15 minutes Median Intra-Service Time: 20 minutes

25th Percentile Intra-Svc Time: 15 min 75th Percentile Intra-Svc Time: 30 min Low: 5 min High: 60 min

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 20 min

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99354	Prolonged physician service; office or outpatient	1.77
2)	99254	Initial inpatient consultation; moderate complexity	2.64
3)	62270	Spinal puncture, therapeutic	1.13
4)	12001	Simple repair of superficial wounds of scalp	1.65
5)	99356	Prolonged physician service; inpatient	1.71

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgment	Median Technical Skill & Physical Effort	Median Psychological Stress
991X1	15 min	20 min	20 min	median = 4.00 mean = 3.60	median = 3.00 mean = 3.30	median = 4.00 mean = 3.77
99354	10 min	37.50 min	10 min	median = 4.00 mean = 3.40	median = 2.50 mean = 2.50	median = 3.00 mean = 3.10
99254	20 min	40 min	20 min	median = 4.00 mean = 3.69	median = 3.00 mean = 3.00	median = 3.00 mean = 3.15
62270	10 min	12.50 min	6.50 min	median = 3.00 mean = 2.83	median = 3.50 mean = 3.25	median = 3.00 mean = 3.00
12001	12 min	20 min	5 min	median = 3.00 mean = 3.00	median = 3.00 mean = 3.33	median = 3.00 mean = 3.17
99356	10 min	40 min	10 min	median = 4.00 mean = 3.82	median = 3.00 mean = 3.27	median = 4.00 mean = 3.64

•The survey respondents indicated a little more pre time for the new CPT code 991X1 compared to the reference CPT codes 99354, 62270, 12001 and 99356. A large number of respondents used these CPT codes as references. The survey respondents concluded that CPT reference codes 62270 and 12001 had less pre and post time compared to 991X1. Both of these reference services also were determined by survey respondents to have significantly less mental effort and judgment, technical skill and physical effort, and psychological stress than 991X1. The majority of the respondents who used 62270 or 12001 (both surgical services) a reference also used an Evaluation and Management (E/M) service with a low RVU as a reference code. One can conclude that these respondents were attempting to use a building block approach to determine the time and value of the new CPT code 991X1.

•A large number of survey respondents used the prolonged physician codes (99354 and 99356) as reference services. The survey respondents suggested that the new CPT code 991X1 has more pre and post time but less intra time than these prolonged service codes. Upon evaluation of the complexity/intensity information, one

could conclude that the survey respondents determined that the new CPT code 991X1 generally had higher levels of complexity/intensity than the prolonged service reference services.

•The survey respondents also compared the new CPT code 991X1 to an initial inpatient consultation of moderate complexity (99254). This reference service was determined to have more intra service time and involved slightly more mental effort and judgment, but involved significantly less technical skill and physical effort, and psychological stress than the new CPT code 991X1.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

Harvard and RUC Update intra time information for key reference services:

CPT Code	Descriptor	Global	Harvard Intra Time	RUC Update Intra Time	Median Survey Intra Time	75% Intra Time
99354	Prolonged physician service; office or outpatient	XXX	60 minutes	60 minutes	37.5 minutes	41.25 minutes
99254	Initial inpatient consultation; moderate complexity	XXX	65 minutes	N/A	40 minutes	65 minutes
62270	Spinal puncture, therapeutic	000	21 minutes	N/A	12.5 minutes	15 minutes
12001	Simple repair of superficial wounds of scalp	010	18 minutes	N/A	20 minutes	20 minutes
99356	Prolonged physician service; inpatient	XXX	60 minutes	60 minutes	40 minutes	42.5 minutes

Note: Using the survey intra time median, it looks as though the survey respondents may have underestimated the time involved in the provision of the reference CPT codes compared to existing intra time data for the reference CPT codes. Using the survey respondents estimated times compared to available Harvard and RUC time data as an indicator, it appears that the survey respondents may have miscalculated the RVU for the sedation/analgesia service, thus undervaluing this service. A more valid measurement of the physician work relative values involved in the sedation/analgesia service would be to examine the survey respondents RVU at the 75% level.

The times assigned by the survey respondents (at the 75% level) to CPT codes 99354, 99254, 62270, 12001 and 99356 are reasonably consistent with the intra service times derived from the Hsiao (Harvard) data and the available RUC update information. This demonstrates that the survey was reasonably reliable for ascertaining the amount of physician time involved in providing these services (consistent with other mechanisms for determining physician time such as consensus panel) as well as maintaining external validity of survey results (the results being similar also substantiates the survey respondents results). Therefore, using the 75th percentile approach, one could conclude that the survey results for relative value units (RVUs) at the 75th percentile are more valid than the median RVU survey results.

Additionally, the Academy distributed this survey to over 15 different pediatric surgical specialties and pediatric medical subspecialties. These specialists provide vastly different physician services requiring unique physician technical skill and physical effort, mental effort and judgment, and psychological stress. However, each of the physician respondents received the same vignette and were asked to evaluate the physician time and the complexity/intensity of the service to ascertain a relative value for the described service. The problem exists in the fact that the majority of these physicians provide vastly different services than the one listed. However, to arrive at an statistically relevant RVU based upon the same information and knowledge of the service, the Academy developed a universal vignette based upon the CPT code proposal submitted to the CPT Editorial Panel. Keeping this in made, it is extraordinary that 79 % of the survey respondents (who answered the question) indicated that the survey vignette represented the typical patient/service. Nonetheless, the mere fact that the physicians evaluating this procedure had varying degrees of experience with this service and vastly different medical backgrounds, creates a dilemma in providing applicable data.

Physicians provide sedation/analgesia for different purposes depending upon varying patient specific requirements such as patient size, age, and weight, not to mention the array of procedures that are provided for which sedation/analgesia may be a necessary component of the service for certain patient populations. Therefore, it must be assumed that the survey respondents were not only using the survey vignette to determine times, complexity/intensity, and the assignment of a RVU, but they were also using their experience with services they provide that require the administration of sedation/analgesia to form the basis for their estimations.

Sedation/analgesia is often patient dependent and is used with a wide variety of procedures and services and it is presumed that the survey results reflect this variation in service preferential. Notwithstanding, it is still difficult to take the survey results at face value without looking at the wide variety of physicians within the survey sample pool. In fact, because of an over sampling of a specific specialty (Emergency Medicine), the survey results reflect a disproportionately large number of survey respondents who used similar reference codes with respectively low RVUs compared to the remaining survey respondents who used reference services with slightly bigger RVUs. In light of the circumstances specified, it was suggested that the 75th percentile more appropriately reflected the wide distribution of survey results and was a better approximation than the survey median for RVU estimation.

As with a majority of the RUC surveys, this survey's external and internal validity was jeopardized by the survey vignette used for estimation, the sampling pool, and the respondents reference services. However, the survey results do provide a rough estimation of the relative value of sedation/analgesia based upon a wide variety of specialists who provide vastly different services, virtually all administering some form of sedation/analgesia

The American Academy of Pediatrics (AAP) consists of 53, 000 general pediatricians, pediatric surgical specialists, and pediatric medical subspecialists. The following table represents those Academy Sections and Committees surveyed for the new CPT code 991X1.

Sample Size Information	Sections/Committees Surveyed	Survey 991X1
A Sample was drawn from the following Academy Sections and Committees:	<u>AAP Sections:</u> Emergency Medicine, Cardiology, Radiology, Rheumatology, Hematology/Oncology, Nephrology, Surgery, Urology, Plastic Surgery, Critical Care, Perinatal Pediatrics, Pulmonology, Otolaryngology and Bronchoesophagology, Ophthalmology, and Gastroenterology <u>AAP Committees:</u> Committee on Practice and Ambulatory Medicine, Committee on Fetus and Newborn, Committee on Drugs, Committee on Pediatric Emergency Medicine, and Resource-Based Relative Value Scale Project Advisory Committee	Sample Size = 387
Incorrect Address		7 Incorrect address = 380
Total Returned Surveys		97 (25.52%)
Return Surveys, Incomplete		2 (0.5%)
Return Surveys, Late		4 (1%)
Returned Surveys, Completed		91 (23.95%)

FREQUENCY INFORMATION

How was this service previously reported? Anesthesia CPT Codes (only if different physician than providing the procedure or service for which sedation/analgesia is required and then not often). There is currently no CPT code available to report the administration of sedation/analgesia by same physician providing a procedure, an evaluation, or a service.

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

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

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

As there is presently no mechanism to report the use of sedation/analgesia, there is not a good way estimate this figure. A very small percentage of anesthesia codes may now be reported as sedation/analgesia. However, since there are currently no codes specifically for sedation/analgesia, it is likely this service usually goes unreported.

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

CPT Code: 991X1 Tracking Number: Global Period: XXXX Recommended RVW: 3.4

CPT Descriptor: **Sedation with or without analgesia (conscious sedation);
intravenous, intramuscular or inhalation.**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A seventy-two year old male presents to the office with a fractured mandible sustained from a fall. His left condyle is moderately displaced medially within the fossa. There is a left sided centric prematurity with a slight right sided open bite. He has a full complement of teeth. This very anxious male will clearly not tolerate closed reduction with intermaxillary fixation. It is clear to the physician that an acceptable reduction will only be accomplished with the use of sedation and analgesia. The patient is administered intravenous doses of fentanyl and midazolam.

Description of Pre-Service Work:

The physician must first perform and document a complete screening examination for sedation and analgesia. This includes a fairly detailed history including the specifics of the current injury, current medications, medication allergies, immunization status, prior injuries and illness and any prior anesthetic experience. The timing and content of the patient's last meal is also of paramount importance. The patient then requires a fairly detailed physical examination. This is directed to assess the patient's stability or suitability for sedation and analgesia, and to rule out any underlying pathology which could be masked by the sedation and analgesia.

Once this screening examination is completed, and providing the patient is determined to be an acceptable candidate for sedation and analgesia, informed consent must then be obtained from the patient and document. This will include a detailed description of the need for sedation and the inherent risks and benefits. The physician will likely discuss the various available or acceptable agents and which agent (s) he or she is recommending for this patient.

Upon obtaining informed consent, the patient is then prepared for the procedure. The physician must calculate, recheck and document the appropriate medication dosage (s). The patient must then be placed on cardiorespiratory monitoring including dynamic EKG and pulse oximetry, and intermittent dynamap blood pressure monitoring. Appropriate equipment to maintain an intact airway and ventilation, if needed, must also be mobilized (i.e. suction apparatus, bag and mask, reversal agents.)

Description of Intra-Service Work:

The intra-service period will vary depending upon the desired level and length of sedation and analgesia and the agent (s) and route of administration determined to be the most appropriate for the patient and service. If the patient is administered an intranasal dose of midazolam (991X2), this requires the slow administration of the medication via catheter in the nares into the nasopharynx. Physician skill is required during the administration of this agent because it may cause some patient discomfort. If the patient is administered intravenous doses of fentanyl and midazolam (991X1), this will require the administration of additional doses of medication.

Description of Post-Service Work:

Once the physician has assessed and documented that adequate sedation is achieved, the physician then proceeds with the procedure. The physician work related to fracture reduction (991X1) or the repair of the laceration (991X2) should not be included in your determination of work for this procedure (administration of sedation and analgesia). The patient is carefully monitored throughout the procedure by an independent observer who has the appropriate training and skills required to assess the patient's vital signs, oxygenation, patient's level of sedation and comfort, and to assist the physician with the management of associated complications. Upon completion of the procedure, the patient is then monitored by the observer and the physician until the patient has reached her or his pre-sedation level of consciousness. The physician then conducts and documents a clinical assessment regarding whether the patient has reached discharge criteria. If so, monitoring is terminated and the patient is discharged to home. The work performed by this independent observer should not be included in your determination of physician work.

CPT Code 991X1

SURVEY DATA:Specialty: American Dental Association/American Association of Oral and Maxillfacial SurgeonsSample Size: 80 Response Rate (%): 38% Median RVW: 3.425th Percentile RVW: 2.65 75th Percentile RVW: 3.5 Low: 1.6 High: 5.14Median Pre-Service Time: 20 Median Intra-Service Time: 4525th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 45 Low: 5 High: 90Median Post-Service Time: Total Time
Day of Procedure: 45**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history @ a problem focused examination @ straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.	0.45
2)	99354	Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g. prolonged care and treatment of an acute asthmatic patient in an outpatient setting); first hour.	1.51

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
99213	0	15	0	1	1	1
99354	0	60	0	3	2	3

ADDITIONAL RATIONALE

Oral and maxillofacial surgeons are accustomed to billing for anesthesia services provided in conjunction with a procedure by using time modifiers. During the survey process many of the respondents questioned why time was not a factor in administering the conscious sedation code described in the above vignette. This may have resulted in confusion regarding the median intra and post service times.

The vignette and pre-, intra- and post- service descriptions used to survey this code were similar to the information used in the surveys conducted by the American Academy of Pediatrics.

FREQUENCY INFORMATION

How was this service previously reported? The service is reported using either the procedure code performed appended with a modifier -47 or by using 00170.

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1 million

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 991X2 Tracking Number: NN2 Global Period: XXX Recommended RVW: 1.85

CPT Descriptor:

Sedation with or without analgesia (conscious sedation);
oral, rectal and/or intranasal

(94760-94762 may not be reported in addition to 991X2)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A three year old child presents to the Emergency Department with a 4 cm long laceration to her face, which was sustained from a fall. The location, size and depth of the laceration will require a very careful and skilled two layer closure. This very anxious child barely tolerates a cursory exam of the wound, and actively resists the application of a topical anesthetic. It is clear to the physician that an acceptable repair will only be accomplished with the use of sedation. The patient is administered an intranasal dose of midazolam.

*The physician work related to the repair of the laceration **SHOULD NOT** be included in your determination of work for this procedure (administration of sedation and analgesia).*

*The work performed by this independent observer **SHOULD NOT** be included in your determination of physician work.*

Description of Pre-Service Work:

The physician must first perform and document a complete screening examination for sedation and analgesia. This includes a fairly detailed history including the specifics of the current injury, current medications, medication allergies, immunization status, prior injuries and illness and any prior anesthetic experience. The timing and content of the patient's last meal is also of paramount importance. The child then requires a fairly detailed physical examination. This is directed to assess the patient's stability or suitability for sedation and analgesia, and to rule out any underlying pathology which could be masked by the sedation and analgesia.

Once this screening examination is completed, and providing the patient is determined to be an acceptable candidate for sedation and analgesia, informed consent must then be obtained from the child's parents and documented. This will include a detailed description of the need for sedation and the inherent risks and benefits. The physician will likely discuss the various available or acceptable agents and which agent(s) he or she is recommending for this patient.

Upon obtaining informed consent, the patient is then prepared for the procedure. The physician must calculate, recheck and document the appropriate medication dosage(s). The child must then be placed on cardiorespiratory monitoring including dynamic EKG and pulse oximetry, and intermittent dynamap blood pressure monitoring. Appropriate equipment to maintain an intact airway and ventilation, if needed, must also be mobilized (i.e., suction apparatus, bag and mask, reversal agents).

Description of Intra-Service Work:

The intra-service period will vary depending upon the desired level and length of sedation and analgesia and the agent(s) and route of administration determined to be the most appropriate for the patient and service. If the patient is administered an intranasal dose of midazolam (991X2), this requires the slow administration of the medication via a catheter in the nares into the nasopharynx. Physician skill is required during the administration of this agent because it may cause some patient discomfort. Upon completion of drug administration, the patient remains monitored and under observation until an acceptable level of sedation has been achieved. The length of this pre-sedation period may vary depending upon the agent, route and dose, and characteristics of the patient. If acceptable levels of sedation and analgesia are not achieved, the child may require the administration of additional doses of medication.

Description of Post-Service Work:

Once the physician has assessed and documented that adequate sedation is achieved, the physician then proceeds with the procedure. The patient is carefully monitored throughout the procedure by an independent observer who has the appropriate training and skills required to assess the patient's vital signs, oxygenation, patient's level of sedation and comfort, and to assist the physician with the management of associated complications. Upon completion of the procedure, the patient is then monitored by the observer and the physician until the child has reached her pre-sedation level of consciousness. The physician then conducts and documents a clinical assessment regarding whether the child has reached discharge criteria. If so, monitoring is terminated and the patient is discharged to home.

SURVEY DATA:

Specialty: American Academy of Pediatrics (AAP)- see additional rationale section

Sample Size: n=380 Response Rate (%): 22.63 % (86) Median RVW: 1.70

25th Percentile RVW: 1.10 75th Percentile RVW: 1.85 Low: 0.18 High: 4.20

Median Pre-Service Time: 15 minutes Median Intra-Service Time: 19 minutes

25th Percentile Intra-Svc Time: 10 min 75th Percentile Intra-Svc Time: 25 min Low: 2 min High: 60 min

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 15 min

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99354	Prolonged physician service; office or outpatient	1.77
2)	99356	Prolonged physician service; inpatient	1.71
3)	62270	Spinal puncture, therapeutic	1.13
4)	12001	Simple repair of superficial wounds of scalp	1.65
5)	99253	Initial inpatient consultation; low complexity	1.82

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgment	Median Technical Skill & Physical Effort	Median Psychologic Stress
991X2	15 min	19 min	15 min	median = 3.00 mean = 3.05	median = 3.00 mean = 3.88	median = 4.00 mean = 3.54
99354	10 min	35 min	10 min	median = 4.00 mean = 3.44	median = 2.50 mean = 2.50	median = 3.00 mean = 3.31
99356	20 min	40 min	12.5 min	median = 4.00 mean = 3.85	median = 3.00 mean = 3.00	median = 4.00 mean = 3.92
62270	8 min	10 min	5 min	median = 3.00 mean = 2.75	median = 4.00 mean = 3.58	median = 2.50 mean = 2.67
12001	12 min	20 min	5 min	median = 3.00 mean = 2.73	median = 4.00 mean = 3.45	median = 3.00 mean = 3.08

•The survey respondents indicated a little more pre time for the new CPT code 991X2 compared to the reference CPT codes 99354, 62270, 12001. A large number of respondents used these CPT codes as references. The survey respondents concluded that CPT reference codes 62270 and 12001 had less pre and post time compared to 991X2. Both of these reference services also were determined by survey respondents to have significantly less mental effort and judgment, technical skill and physical effort, and psychological stress than 991X2 (based on the mean values). The majority of the respondents who used 62270 or 12001 (both surgical services) a reference also used an Evaluation and Management (E/M) service with a low RVU as a reference code. One can conclude that these respondents were attempting to use a building block approach to determine the time and value of the new CPT code 991X2.

•A large number of survey respondents used the prolonged physician codes (99354 and 99356) as reference services. The survey respondents suggested that the new CPT code 991X2 had about the same pre time, more post time, but less intra time than these prolonged service codes. Upon evaluation of the complexity/intensity information, one could conclude that the survey respondents determined that the new CPT code 991X2 involved greater technical skill and physical effort, but less mental effort and judgment than the prolonged service reference services.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

Harvard and RUC Update intra time information for key reference services:

CPT Code	Descriptor	Global	Harvard Intra Time	RUC Update Intra Time	Median Survey Intra Time	75% Intra Time
99354	Prolonged physician service; office or outpatient	XXX	60 minutes	60 minutes	35 minutes	50 minutes
99356	Prolonged physician service; inpatient	XXX	60 minutes	60 minutes	40 minutes	40 minutes
62270	Spinal puncture, therapeutic	000	21 minutes	N/A	10 minutes	11.25 minutes
12001	Simple repair of superficial wounds of scalp	010	18 minutes	N/A	20 minutes	20 minutes

Note: Using the survey intra time median, it look as though the survey respondents may have underestimated the time involved in the provision of the reference CPT codes compared to existing intra time data. Using the survey times compared to available time data as an indicator, it appears that the survey respondents may have miscalculated the RVU for the sedation/analgesia service, thus undervaluing this service. A more valid measurement of the physician work relative values involved in the sedation/analgesia service would be to examine the survey respondents RVU at the 75 % level.

The times assigned by the survey respondents (at the 75 % level) to CPT codes 99354, 99254, 62270, 12001 and 99356 are reasonably consistent with the intra service times derived from the Hsiao (Harvard) data and the available RUC update information. This demonstrates that the survey was reasonably reliable for ascertaining the amount of physician time involved in providing these services (consistent with other mechanisms for determining physician time such as consensus panel) as well as maintaining external validity of survey results (the results being similar also substantiates the survey respondents results). Therefore, using the 75th percentile approach, one could conclude that the survey results for relative value units (RVUs) at the 75th percentile are more valid than the median RVU survey results.

Additionally, the Academy distributed this survey to over 15 different pediatric surgical specialties and pediatric medical subspecialties. These specialists provide vastly different physician services requiring unique physician technical skill and physical effort, mental effort and judgment, and psychological stress. However, each of the physician respondents received the same vignette and were asked to evaluate the physician time and the complexity/intensity of the service to ascertain a relative value for the described service. The problem exists in the fact that the majority of these physicians provide vastly different services than the one listed. However, to arrive at an statistically relevant RVU based upon the same information and knowledge of the service, the Academy developed a universal vignette based upon the CPT code proposal submitted to the CPT Editorial Panel. Keeping this in made, it is extraordinary that 76 % of the survey respondents (who answered the question) indicated that the survey vignette represented the typical patient/service. Nonetheless, the mere fact that the physicians evaluating this procedure had varying degrees of experience with this service and vastly different medical backgrounds, creates a dilemma in providing applicable data.

Physicians provide sedation/analgesia for different purposes depending upon varying patient specific requirements such as patient size, age, and weight, not to mention the array of procedures that are provided for

Therefore, it must be assumed that the survey respondents were not only using the survey vignette to determine times, complexity/intensity, and the assignment of a RVU, but they were also using their experience with services they provide that require the administration of sedation/analgesia to form the basis for their estimations.

Sedation/analgesia is often patient dependent and is used with a wide variety of procedures and services and it is presumed that the survey results reflect this variation in service preferential. Notwithstanding, it is still difficult to take the survey results at face value without looking at the wide variety of physicians within the survey sample pool. In fact, because of an over sampling of a specific specialty (Emergency Medicine), the survey results reflect a disproportionately large number of survey respondents who used similar reference codes with respectively low RVUs compared to the remaining survey respondents who used reference services with slightly bigger RVUs. In light of the circumstances specified, it was suggested that the 75th percentile more appropriately reflected the wide distribution of survey results and was a better approximation than the survey median for RVU estimation.

As with a majority of the RUC surveys, this survey's external and internal validity was jeopardized by the survey vignette used for estimation, the sampling pool, and the respondents reference services. However, the survey results do provide a rough estimation of the relative value of sedation/analgesia based upon a wide variety of specialists who provide vastly different services, virtually all administering some form of sedation/analgesia

The American Academy of Pediatrics (AAP) consists of 53, 000 general pediatricians, pediatric surgical specialists, and pediatric medical subspecialists. The following table represents those Academy Sections and Committees surveyed for the new CPT code 991X2.

Sample Size Information	Sections/Committees Surveyed	Survey 991X1
A Sample was drawn from the following Academy Sections and Committees:	<u>AAP Sections:</u> Emergency Medicine, Cardiology, Radiology, Rheumatology, Hematology/Oncology, Nephrology, Surgery, Urology, Plastic Surgery, Critical Care, Perinatal Pediatrics, Pulmonology, Otolaryngology and Bronchoesophagology, Ophthalmology, and Gastroenterology <u>AAP Committees:</u> Committee on Practice and Ambulatory Medicine, Committee on Fetus and Newborn, Committee on Drugs, Committee on Pediatric Emergency Medicine, and Resource-Based Relative Value Scale Project Advisory Committee	Sample Size = 387
Incorrect Address		7 Incorrect address = 380
Total Returned Surveys		92 (24.21%)
Return Surveys, Incomplete		2 (0.5%)
Return Surveys, Late		4 (1%)
Returned Surveys, Completed		86 (22.63%)

FREQUENCY INFORMATION

How was this service previously reported? Anesthesia CPT Codes (only if different physician than providing the procedure or service for which sedation/analgesia is required and then not often) There is currently no CPT code available to report the administration of sedation/analgesia by same physician providing a procedure, evaluation or service

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

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

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

As there is presently no mechanism to report the use of sedation/analgesia, there is not a good way estimate this figure. A very small percentage of anesthesia codes may now be reported as sedation/analgesia. However, since there are currently no codes specifically for sedation/analgesia, it is likely this service usually goes unreported.

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

CPT Code: 991X2 Tracking Number: Global Period: XXXX Recommended RVW: 2.05

CPT Descriptor: Sedation with or without analgesia (conscious sedation);
oral, rectal and/or intranasal.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A three year old child presents to the Emergency Department with a 4 cm long laceration to her face, which was sustained from a fall. The location, size and depth of the laceration will require a very careful and skilled two layer closure. This very anxious child barely tolerates a cursory exam of the wound, and actively resists the application of a topical anesthetic.

It is clear to the physician that an acceptable repair will only be accomplished with the use of sedation. The patient is administered an intranasal dose of midazolam

Description of Pre-Service Work:

The physician must first perform and document a complete screening examination for sedation and analgesia. This includes a fairly detailed history including the specifics of the current injury, current medications, medication allergies, immunization status, prior injuries and illness and any prior anesthetic experience. The timing and content of the patient's last meal is also of paramount importance. The patient then requires a fairly detailed physical examination. This is directed to assess the patient's stability or suitability for sedation and analgesia, and to rule out any underlying pathology which could be masked by the sedation and analgesia.

Once this screening examination is completed, and providing the patient is determined to be an acceptable candidate for sedation and analgesia, informed consent must then be obtained from the patient and document. This will include a detailed description of the need for sedation and the inherent risks and benefits. The physician will likely discuss the various available or acceptable agents and which agent (s) he or she is recommending for this patient.

Upon obtaining informed consent, the patient is then prepared for the procedure. The physician must calculate, recheck and document the appropriate medication dosage (s). The patient must then be placed on cardiorespiratory monitoring including dynamic EKG and pulse oximetry, and intermittent dynamap blood pressure monitoring. Appropriate equipment to maintain an intact airway and ventilation, if needed, must also be mobilized (i.e. suction apparatus, bag and mask, reversal agents.)

Description of Intra-Service Work:

The intra-service period will vary depending upon the desired level and length of sedation and analgesia and the agent (s) and route of administration determined to be the most appropriate for the patient and service. If the patient is administered an intranasal dose of midazolam (991X2), this requires the slow administration of the medication via catheter in the nares into the nasopharynx. Physician skill is required during the administration of this agent because it may cause some patient discomfort. If the patient is administered intravenous doses of fentanyl and midazolam (991X1), this will require the administration of additional doses of medication.

Description of Post-Service Work:

Once the physician has assessed and documented that adequate sedation is achieved, the physician then proceeds with the procedure. The physician work related to fracture reduction (991X1) or the repair of the laceration (991X2) should not be included in your determination of work for this procedure (administration of sedation and analgesia). The patient is carefully monitored throughout the procedure by an independent observer who has the appropriate training and skills required to assess the patient's vital signs, oxygenation, patient's level of sedation and comfort, and to assist the physician with the management of associated complications. Upon completion of the procedure, the patient is then monitored by the observer and the physician until the patient has reached her or his pre-sedation level of consciousness. The physician then conducts and documents a clinical assessment regarding whether the patient has reached discharge criteria. If so, monitoring is terminated and the patient is discharged to home. The work performed by this independent observer should not be included in your determination of physician work.

CPT Code 991X2

SURVEY DATA:Specialty: American Dental Association/American Association of Oral and Maxillofacial SurgeonsSample Size: 80 Response Rate (%): 38% Median RVW: 2.0525th Percentile RVW: 1.75 75th Percentile RVW: 2.5 Low: 1.21 High: 4.64Median Pre-Service Time: 15 Median Intra-Service Time: 2525th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 30 Low: 5 High: 60Median Post-Service Time: Total Time
Day of Procedure: 30**KEY REFERENCE SERVICE(S):**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 99212	Office or Other outpatient visit for the evaluation and management of an established patient, which requires at least tow of these three key components: a problem focused history @ a problem focused examination @ straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.	0.45
2) 99354	Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g. prolonged care and treatment of an acute asthmatic patient in an outpatient setting); first hour.	1.51

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
99212	0	10	0	1	1	1
99354	0	60	0	3	2	3

ADDITIONAL RATIONALE

Oral and maxillofacial surgeons are accustomed to billing for anesthesia services provided in conjunction with a procedure by using time modifiers. During the survey process many of the respondents questioned why time was not a factor in administering the conscious sedation code described in the above vignette. This may have resulted in confusion regarding the median intra and post service times.

The vignette and pre-, intra- and post- service descriptions used to survey this code were similar to the information used in the surveys conducted by the American Academy of Pediatrics.

FREQUENCY INFORMATION

How was this service previously reported? The service is reported using either the procedure code performed appended with a modifier -47 or by using 00170.

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 250,000

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Observation Same Day Discharge Services - Tab 17

Three new codes have been developed to describe observation same day hospital discharge services: 99234, *Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and 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 presenting problem(s) requiring admission of low severity,* 99235, *Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission of moderate severity,* and 99236, *Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission of high severity.* The RUC expressed concern over the time frame that these codes incorporate. They specify that the patient must be admitted and discharged on the same date. The RUC felt that a calendar day is an arbitrary cut off point. The RUC recommends that the physician work is the same when admitting a patient to hospital observation at 9:00 pm with a discharge at 9:00 am and admitting a patient to observation at 9:00 am and discharging at 9:00 pm.

The RUC recommends that 99234, 99235, and 99236 should be valued based on a combination of hospital observation services, 99218, 99219, and 99220 and 99238 *Hospital discharge day management* at each of the three appropriate levels. The calculation would be as follows:

99234 = 99218 *Observation care* (1.28) + 99238 *Hospital Discharge Day Mgt.* (1.28) = 2.56
99235 = 99219 *Observation care* (2.14) + 99238 *Hospital Discharge Day Mgt.* (1.28) = 3.42
99236 = 99220 *Observation care* (2.99) + 99238 *Hospital Discharge Day Mgt.* (1.28) = 4.27

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
OBSERVATION OR INPATIENT CARE SERVICES (INCLUDING ADMISSION AND DISCHARGE SERVICES)				
<p>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.</p> <p>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.</p> <p>For patients admitted to observation or inpatient care and discharged on a different date, see codes 99218-99220 and 99217, or 99221-99223 and 99238-99239.</p>				
•99234	OO1	<p>Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components:</p> <ul style="list-style-type: none"> • a detailed or comprehensive history; • a detailed or comprehensive examination; and • medical decision making that is straightforward or of low complexity. <p>Counseling and/or coordination of care with other providers or agencies are provided</p>	XXX	2.56

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<p>consistent with the nature of the problem(s) and the patient's and/or family's needs.</p> <p>Usually the presenting problem(s) requiring admission of low severity.</p>		
•99235	OO2	<p>Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components:</p> <ul style="list-style-type: none"> • a comprehensive history; • a comprehensive examination; and • medical decision making of moderate complexity. <p>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.</p> <p>Usually the presenting problem(s) requiring admission of moderate severity.</p>	XXX	3.42
•99236	OO3	<p>Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key</p>	XXX	4.27

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<p>components:</p> <ul style="list-style-type: none"> • a comprehensive history; • a comprehensive examination; and • medical decision making of high complexity. <p>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.</p> <p>Usually the presenting problem(s) requiring admission of high severity.</p>		
<p>Initial Observation Care</p> <p>New or Established Patient</p> <p>Observation care discharge of a patient from “observation status” includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. <u>For observation or inpatient hospital care including the admission and discharge of the patient on the same date, see codes 99234-99236 as appropriate.</u></p> <p>99217 Observation care discharge day management (This code is to be utilized by the physician to report all services provided to a patient on discharge from “observation status” if the discharge is on other than the initial date of “observation status”. To report services to a patient designated as “observation status” or “inpatient status” and discharged on the same date, <u>use only the codes for Initial Observation Services (99218-99220)</u>) <u>use the codes for Observation or Inpatient Care Services (Including Admission and Discharge Services, 99234-99236 as appropriate.</u></p>				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>INITIAL OBSERVATION CARE</p> <p>NEW OR ESTABLISHED PATIENT</p> <p>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</p> <p>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 15). 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 codes (99221-99223). <u>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.</u> Do not report observation discharge (92217) in conjunction with the a hospital admission.</p> <p>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 supervision physician</p> <p>HOSPITAL INPATIENT SERVICES</p> <p>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 CPT.</p> <p>For definitions of key components and commonly used terms, please see Evaluation and Management Services Guidelines. For Hospital Observation Services, see 99218-99220. <u>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.</u></p> <p>INITIAL HOSPITAL CARE</p> <p>NEW OR ESTABLISHED PATIENT</p>				

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>The following codes are used to report the first hospital inpatient encounter with the patient by the admitting physician.</p> <p>For initial inpatient encounters by physicians other than the admitting physician, see initial inpatient consultation codes (99251-99255) or subsequent hospital care codes (99231-99233) as appropriate.</p> <p>When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service (eg, hospital emergency department, observation status in a hospital, physician's office, nursing facility) all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The inpatient care level of the service reported.</p> <p>.....</p> <p>Evaluation and management services on the same date provided in sites other than the hospital that are related to the admission should NOT be reported separately. <u>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.</u></p> <p>HOSPITAL DISCHARGE SERVICES</p> <p>The hospital discharge day management codes are to be used to report the total duration of time spent by a physician for final hospital discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, even if the time spent by the physician on that date is not continuous. Instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms. <u>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.</u></p> <p>99238 Hospital discharge day management; 30 minutes or less</p> <p>99239 more than 30 minutes</p> <p>(These codes are to be utilized by the physician to report all services provided to a patient on the date of discharge, if other than the initial date of inpatient status. To report services to a patient who is admitted as an inpatient, and discharged on the same date, use only the codes for Initial Hospital Inpatient Services, 99221-99233 see codes 99234-99236 for observation or inpatient hospital care including the</p>				

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<u>admission and discharge of the patient on the same date.</u> <i>To report concurrent care services provided by a physician(s) other than the attending physician, use subsequent hospital care codes (99231-99233) on the day of discharge.)</i> <i>(For Observation Care Discharge, use 99217)</i> <u>(For observation or inpatient hospital care including the admission and discharge of the patient on the same date, see 99234-99236)</u> <u>(For Nursing Facility Care Discharge, see 99315, 99316)</u> <i>(For discharge services provided to newborns admitted and discharged on the same date, see 99435)</i>				

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATIONCPT Code: 992x1 Tracking Number: 001 Global Period: xxx Recommended RVW: 2.1

CPT Descriptor: Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components:

- a detailed or comprehensive history;
- a detailed or comprehensive examination; and
- 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 presenting problem(s) requiring admission are of low severity.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 19 y/o pregnant patient (9 weeks gestation) presents to the ED complaining of persistent vomiting for one day.

Description of Pre-Service Work:

Description of Intra-Service Work: A detailed history is taken. The patient gives no history consistent with infection, but does recall a similar occurrence with her previous pregnancy. She also complains of some dizziness upon standing. A detailed examination of performed and elicits findings associated with moderate dehydration, including postural hypotension. Intravenous therapy and anti-emetics are initiated. Diagnostics are consistent with dehydration. The patient is placed on observation status, with periodic reassessments. Following cessation of postural hypotension an after demonstrating the ability to retain p.o. fluids, the patient is discharged, 9 hours after initial presentation, with instructions and a prescription for anti-emetic medication.

Description of Post-Service Work:**SURVEY DATA:**

Specialty: American Academy of Pediatrics. American College of Emergency Physicians

Sample Size: 425 (AAP= 225) (ACEP= 200) Response Rate (%): 94 (22%) (AAP= 46) (ACEP= 48)

Median RVW: 2.1

25th Percentile RVW: 1.82 75th Percentile RVW: 2.75 Low: 1.2 High: 2.75

Median Pre-Service Time: 10 (AAP only) Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 35 75th Percentile Intra-Svc Time: 75 Low: 15 High: 540

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 15 (AAP only)

ICU: _____

Other Hospital: _____

Office: _____

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99285	Emergency Department Visit	1.28
2)	99218	Initial Hospital Observation	1.95

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
992x1	10*	60	15*	3	3	3
99218	10*	35	10*	3	2	3
99284	N/A	N/A	N/A	4	3	4

*Determined by AAP only.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

This service is a result of a recommendation to CPT made by the Ohio Medical Society. It seems reasonable to assume that this service is meant to encompass a greater service, provided on a single date, than the current Initial Observation Care (99218) or Initial Hospital Care (99221), since it would be highly unusual to incorporate new services into CPT that were similar in work to already existing codes. The question is, how different from the existing codes are the new codes. This question can be looked at in a number of ways, but the two major perspectives are: survey data and some type of "building block" methodology.

The median RVW of the overall survey was 2.1. When the surveys were culled for those who indicated (either by a "zero" count or no number) that they had not provided the service over the past year, the RVW range for the remaining surveys (64.5% of the total respondents) was: 25th% = 1.82, Median = 2.1, 75th% = 2.9.

In reviewing the surveys, it became apparent that a substantial number of the respondents utilized some form of "building block" methodology, either an ED E&M plus an Observation Care code (initial or discharge) or two Observation Codes (initial and discharge). The number of respondents who appeared to use this methodology represented 42% of total respondents, and the median RVW for this group was 2.56.

Another "building block" perspective can be obtained by looking at the two most frequently cited reference codes: 99218 (RVW = 1.28) and 99284 (RVW = 1.95). If a 30% "overlap" of these two services in the new service is postulated (i.e., the total work of the two services is reduced by 30%), then the resultant RVW would be 2.26. Another perspective can be obtained by considering the initial service to be the most often referenced ED E&M service supplemented by some reduced Observation Care Discharge service (reduced by 50% at this level of service) resulting in a RVW of 2.59 (i.e., $1.95 + .5 [1.28]$).

In reviewing all these perspectives we think the best measure, in this instance, is the result obtained from the surveys of those physicians who provide the service, an RVW of 2.1.

FREQUENCY INFORMATION

How was this service previously reported? 99284, 99219

How often do physicians in your specialty perform this service? Commonly ☒ Sometimes Rarely

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

Is this service performed by many physicians across the United States? Yes ☒ No

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**CPT Code: 992x2 Tracking Number: 002 Global Period: xxx Recommended RVW: 3.1

CPT Descriptor: Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making that is of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually the presenting problem(s) requiring admission are of moderate severity.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 18 y/o patient presents to the ED with respiratory compromise.

Description of Pre-Service Work:

Description of Intra-Service Work: A comprehensive history is obtained with some difficulty since the patient is unable to speak complete sentences. The patient has a history of asthma and has been hospitalized twice for this condition, but not recently. A comprehensive multi-system examination is performed and elicits that the patient has labored breathing, is using accessory muscles, and has muffled wheezing in all lung fields. Coincident with the obtaining of blood samples, treatment is initiated with oxygen, aerosol bronchodilators, IV fluids, and IV steroids. After 2 additional, but only partially successful, courses of therapy over a 2 hour period, the patient is placed on observation status. Additional diagnostics are ordered, and respiratory therapy is continued based upon periodic reassessments by the physician. Following cessation of wheezing and demonstration of an acceptable peak flow rate, the patient is discharged, 10 hours after initial presentation, with instructions and a modified prescription regimen.

Description of Post-Service Work:**SURVEY DATA:**

Specialty: American Academy of Pediatrics, American College of Emergency Physicians

Sample Size: 425 (AAP= 225) (ACEP= 200) Response Rate (%): 92 (22%) (AAP= 44) (ACEP= 48)

Median RVW: 3.0

25th Percentile RVW: 2.4 75th Percentile RVW: 3.75 Low: 1.6 High: 6.0

Median Pre-Service Time: 10 (AAP only) Median Intra-Service Time: 75

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 110 Low: 25 High: 600

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 15 (AAP only)

ICU: _____

Other Hospital: _____

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99219	Initial Observation Care	2.14
2)	99284	Emergency Department Visit	1.95
3)	99285	Emergency Department Visit	3.06

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
992x2	10*	75	15*	4	3	4
99219	10*	55	10*	4	3	4
99284	N/A	N/A	N/A	4	3	4
99285	N/A	N/A	N/A	5	4	4

* Determined by AAP only.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

This service is a result of a recommendation to CPT made by the Ohio Medical Society. It seems reasonable to assume that this service is meant to encompass a greater service, provided on a single date, than the current Initial Observation Care (99219) or Initial Hospital Care (99222), since it would be highly unusual to incorporate new services into CPT that were similar in work to already existing codes. The question is, how different from the existing codes are the new codes. This question can be looked at in a number of ways, but the two major perspectives are: survey data and some type of "building block" methodology.

The surveys were completed by emergency physicians and pediatricians (some of whom specialize in pediatric emergency medicine). The median RVW of the overall survey was 3.0. When the surveys were culled for those who indicated (either by a "zero" count or no number) that they had not provided the service over the past year, the RVW range for the remaining surveys (66% of the total respondents) was: 25th% = 2.25, Median = 3.1, 75th% = 3.7.

In reviewing the surveys, it became apparent that a substantial number of the respondents utilized some form of "building block" methodology, either an ED E&M plus an Observation Care code (initial or discharge) or two Observation Codes (initial and discharge). The number of respondents who appeared to use this methodology represented 43% of total respondents, and the median RVW for this group was 3.1.

Another "building block" perspective can be obtained by looking at the three most frequently cited reference codes: 99219 (RVW = 2.14), 99284 (RVW = 1.95), and 99285 (RVW = 3.06). If a 30% "overlap" of an ED E&M service and the Initial Observation Care service in the new service is postulated (i.e., the total work of the two services is reduced by 30%), then the resultant RVWs would be 2.86 (99284 & 99219) and 3.64 (99285 & 99219) respectively. Another perspective can be obtained by considering the initial service to be one of the referenced ED E&M services supplemented by some reduced Observation Care Discharge service

(reduced by 40% at this level of service) resulting in RVWs of 2.71 (i.e., $1.95 + .6 [1.28]$) ~~and~~ ^{P.7} 3.82 (i.e., $3.06 + .6 [1.28]$) respectively.

In reviewing all these perspectives we think the best measure, in this instance, is the result obtained from the surveys of those physicians who provide the service, an RVW of 3.1.

FREQUENCY INFORMATION

How was this service previously reported? 99285, 99220

How often do physicians in your specialty perform this service? Commonly ☒ Sometimes ☐ Rarely

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

Is this service performed by many physicians across the United States? ☐ Yes ☒ No

SUMMARY OF RECOMMENDATIONCPT Code: 992x3 Tracking Number: 003 Global Period: xxx Recommended RVW: 4.34

CPT Descriptor: Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making that is 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) requiring admission are of high severity.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62 y/o patient brought to the ED because of dyspnea and chest pressure..

Description of Pre-Service Work:

Description of Intra-Service Work: A comprehensive history is obtained, which includes increasing exertional dyspnea over the past few days, known coronary artery disease, an MI 2 years prior, and 2 episodes of CHF last year. A comprehensive multi-system examination is performed. Diagnostics reveal non-specific ST changes inferiorly, CHF, and high normal CK with a normal index. Oxygen, nitrates, and diuretics are initiated. 2 hours post-admit to the ED, the chest pressure has resolved, but the dyspnea remains. The patient is placed on observation status. Additional diagnostics are ordered, and therapy is continued based upon periodic reassessments by the physician. Following cessation of dyspnea, and with no change in serial EKGs, and CK-MBs, the patient is discharged 12 hours after presenting to the ED.

Description of Post-Service Work:**SURVEY DATA:**Specialty: American College of Emergency PhysiciansSample Size: 200 Response Rate (%): 47 (24%) Median RVW: 4.2525th Percentile RVW: 3.65 75th Percentile RVW: 5.05 Low: 2.99 High: 9Median Pre-Service Time: -- Median Intra-Service Time: 11025th Percentile Intra-Svc Time: 90 75th Percentile Intra-Svc Time: 150 Low: 45 High: 300Median Post-Service Time: Total Time Number of VisitsDay of Procedure: --ICU: Other Hospital: Office:

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99285	Emergency Department Visit	3.06
2)	99220	Initial Hospital Observation	2.99
3)	99255	Initial Inpatient Consultation	3.65

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

<u>CPT Code</u>	<u>Median Pre-Time</u>	<u>Median Intra-Time</u>	<u>Median Post-Time</u>	<u>Median Mental Effort & Judgement</u>	<u>Median Technical Skill & Physical Effort</u>	<u>Median Psychological Stress</u>
992x3	---	110	---	5	4	5
99285	N/A	N/A	N/A	5	5	5
99220	---	65	---	5	4	5
99255	---	110	---	5	4	4

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

This service is a result of a recommendation to CPT made by the Ohio Medical Society. It seems reasonable to assume that this service is meant to encompass a greater service, provided on a single date, than the current Initial Observation Care (99220) or Initial Hospital Care (99223), since it would be highly unusual to incorporate new services into CPT that were similar in work to already existing codes. The question is, how different from the existing codes are the new codes. This question can be looked at in a number of ways, but the two major perspectives are: survey data and some type of "building block" methodology.

The median RVW of the overall survey was 4.25. When the surveys were culled for those who indicated (either by a "zero" count or no number) that they had not provided the service over the past year, the RVW range for the remaining surveys (36% of the total respondents) was: 25th% = 3.75, Median = 4.34, 75th% = 5.0.

In reviewing the surveys, it became apparent that a substantial number of the respondents utilized some form of "building block" methodology, either an ED E&M plus an Observation Care code (initial or discharge) or two Observation Codes (initial and discharge). The number of respondents who appeared to use this methodology represented 36% of total respondents, and the median RVW for this group was 4.59.

Another "building block" perspective can be obtained by looking at the two most frequently cited reference codes: 99285 (RVW = 3.06) and 99220 (RVW = 2.99). If a 30% "overlap" of these two services in the new service is postulated (i.e., the total work of the two services is reduced by 30%), then the resultant RVW would be 4.24. Another perspective can be obtained by considering the initial service to be the most often referenced ED E&M service supplemented by some reduced Observation Care Discharge service (reduced by 30% at this level of service) resulting in a RVW of 3.96 (i.e., $3.06 + .7 [1.28]$).

In reviewing all these perspectives we think the best measure, in this instance, is the result obtained from the surveys of those physicians who provide the service, an RVW of 4.34.

FREQUENCY INFORMATION

How was this service previously reported? 99285, 99220

How often do physicians in your specialty perform this service? Commonly ☒ Sometimes Rarely

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

Is this service performed by many physicians across the United States? Yes ☒ No

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Care Plan Oversight Services - Tab 18

The current code for care plan oversight 99375 (work rvu = 1.73) has been replaced with codes that differentiate between care plan oversight services provided to patients in a number of facilities including nursing homes, hospice facilities, and home care settings. The codes represent a culmination of physician work that has occurred within a calendar month.

The RUC recommends that the codes 99375, 99378, and 99380, which describe more than 30 minutes of care plan oversight, be assigned the same work rvu of the existing code 99375 (1.73). The RUC recommends that the new codes for care plan oversight for 15-29 minutes be assigned a work rvu of 1.10, which incorporates the same level of intensity for an average of 20 minutes per month.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<i>The work involved in providing very low intensity or infrequent supervision services is included in the pre- and post-encounter work for home, office/outpatient and nursing facility or domiciliary visit codes. Care plan oversight services provided which are less than 30 minutes during a 30 day period are considered part of patient evaluation and management and should not be reported separately</i>				
•99374	AE1	Physician supervision of a patient under care of home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	XXX	1.10
99375	AE2	Physician supervision of patients under care of home health agencies, hospice or nursing facility patients (patient not present) requiring complex and multidisciplinary care modalities involving regular	XXX	1.73

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

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) with other health care professionals involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a 30-day period; 30-60 minutes <u>30 minutes or more</u>		
99376	AE3	—greater than 60 minutes (99376 has been deleted. To report, see 99375, 99378, 99380)	XXX	NA
•99377	AE4	Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) with other health care professionals involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	XXX	1.10
•99378	AE5	30 minutes or more	XXX	1.73
•99379	AE6	Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) with other health care professionals involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	XXX	1.10
•99380	AE7	30 minutes or more	XXX	1.73

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 993X1 Tracking Number: (AE1) Global Period: calendar month Recommended RVW: 1.1

Care Plan Oversight Services for Patients in the Home Health Setting; 15-29 minutes.

CLINICAL DESCRIPTION OF SERVICE:

Physician supervision of a patient under care of home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes.

Vignette Used in Survey:

84 year old male discharged home from rehab setting after CVA complicating underlying diabetes, hypertension with ASHD, requiring insulin management and Coumadin. Home health agency is providing weekly nursing visit, protime draws, faxing blood sugar records and patient is progressing well with PT & OT. Nutrition seems adequate. Multiple home health agency forms, verbal orders to sign, lab work to review, phone calls from visiting nurse are needed plus charting time; without face to face visit planned until 6th week when patient more ambulatory. Total physician time 25 minutes for first month, not counting staff time to file lab orders, prescriptions and handling forms.

SURVEY DATA:

Specialty: Internal Medicine (ASIM) and Family Medicine (AAFP)

Sample Size: 27/174 Response Rate (%): 15.5% Median RVW: 1.1

25th Percentile RVW: 0.76 75th Percentile RVW: 1.29 Low: 0.57 High: 2.2

Median Pre-Service Time: 5 minutes Median Intra-Service Time: 20 minutes

25th Percentile Intra-Svc Time: 11 minutes 75th Percentile Intra-Svc Time: 25 minutes

Low Intra-Svc Time: 0 minutes High Intra-Svc Time: 30 minutes

Median Post-Service Time: 9 minutes

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 99214	Established patient outpatient/office visit	1.1
2) 99238	Hospital discharge day management, 30 minutes or less	1.28
3) 99213	Established patient outpatient/office visit	0.67

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median M.E.&J.	Median T.S. & P.E.	Median P.S.
993X1(AE1)	5 minutes	20 minutes	9 minutes	3	2	3
99214	5 minutes	25 minutes	10 minutes	4	4	3.5
99238	5 minutes	20 minutes	10 minutes	3	2	3
99213	5 minutes	15 minutes	5 minutes	3	2.5	2.5

ADDITIONAL RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

FREQUENCY INFORMATION

How was this service previously reported? 99375

How often do physicians in your specialty perform this service XX Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period?
Median response was 30 times per respondent per year.

Is this service performed by many physicians across the United States? XX Yes No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 99375 Tracking Number: (AE2) Global Period: calendar month Recommended RVW: 1.65

99375 Care Plan Oversight Services for Patients in the Home Health Setting; 30 or more minutes.

CLINICAL DESCRIPTION OF SERVICE:

Physician supervision of a patient under care of home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 or more minutes.

Vignette Used in Survey:

84 year old male discharged home from rehab setting after CVA complicating underlying diabetes, hypertension with ASHD, having development of edema and mild dyspnea with 10 pound weight gain. Patient requires several changes in insulin and Coumadin management. Home health agency is providing weekly nursing visit, protime draws, faxing blood sugar records and patient is progressing with PT & OT. Discussion with speech therapist about mild dysphagia problem with diet modifications needed. Multiple home health agency forms, verbal orders to sign, extensive lab work and monitoring of an intercurrent UTI to review, phone calls from visiting nurse are needed plus charting time; without face to face visit planned until 6th week when patient more ambulatory. Total physician time 50 minutes for first month, not counting staff time to file lab orders, prescriptions and handling forms.

SURVEY DATA:

Specialty: Internal Medicine (ASIM) and Family Medicine (AAFP)

Sample Size: 27/174 Response Rate (%): 15.5% Median RVW: 1.65

25th Percentile RVW: 1.27 75th Percentile RVW: 2.1 Low: 0.75 High: 6.42

Median Pre-Service Time: 10 minutes Median Intra-Service Time: 32 minutes

25th Percentile Intra-Svc Time: 30 minutes 75th Percentile Intra-Svc Time: 48 minutes

Low Intra-Svc Time: 0 minutes High Intra-Svc Time: 60 minutes

Median Post-Service Time: 15 minutes

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 99214	Established patient outpatient/office visit	1.10
2) 99215	Established patient outpatient/office visit	1.77
3) 99233	Subsequent hospital care	1.51

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median M.E.&J.	Median T.S. & P.E.	Median P.S.
99375(AE2)	10 minutes	32 minutes	15 minutes	4	3	4
99214	5 minutes	20 minutes	10 minutes	3	3	3
99215	5 minutes	40 minutes	10 minutes	4	4	4
99233	5 minutes	25 minutes	10 minutes	3	3	3

ADDITIONAL RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

FREQUENCY INFORMATION

How was this service previously reported? 99375

How often do physicians in your specialty perform this service XX Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period?
Median response was 13.5 times per respondent per year.

Is this service performed by many physicians across the United States? XX Yes No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 993X2 Tracking Number: (AE4) Global Period: calendar month Recommended RVW: 1.03

993X2 Care Plan Oversight Services for Patients in the Hospice Setting; 15-29 minutes.

CLINICAL DESCRIPTION OF SERVICE:

Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes.

Vignette Used in Survey:

First month of terminal home care of 58 year old woman with advanced intraabdominal ovarian cancer. Diuretic management of edema and ascites, pain management with oral then dermal patch medication is coordinated, with several physician phone contacts with nurse, family and MSW. Documentation includes review and modification of care plan and certifications from nursing, MSW, pharmacy and DME. Limited lab work to review. Approximate physician time of service is 20 minutes, not counting staff time to file lab orders, prescriptions and handling forms.

Specialty: Internal Medicine (ASIM) and Family Medicine (AAFP)

Sample Size: 26/174 Response Rate (%): 14.9% Median RVW: 1.03

25th Percentile RVW: 0.67 75th Percentile RVW: 1.25 Low: 0.4 High: 2.5

Median Pre-Service Time: 5 minutes Median Intra-Service Time: 15 minutes

25th Percentile Intra-Svc Time: 10 minutes 75th Percentile Intra-Svc Time: 20 minutes

Low Intra-Svc Time: 0 minutes High Intra-Svc Time: 20 minutes

Median Post-Service Time: 5 minutes

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 99213	Established patient outpatient/office visit	0.67
2) 99212	Established patient outpatient/office visit	0.45

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median - M.E.&J.	Median T.S. & P.E.	Median P.S.
993X2(AE4)	5 minutes	15 minutes	5 minutes	3	2.5	3
99213	5 minutes	15 minutes	5 minutes	3	3	2.5
99212	5 minutes	10 minutes	5 minutes	3	2	2

ADDITIONAL RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

FREQUENCY INFORMATION -

How was this service previously reported? 99375

How often do physicians in your specialty perform this service XX Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period?
Median response was 5 times per respondent per year.

Is this service performed by many physicians across the United States? XX Yes No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 993X3 Tracking Number: (AE5) Global Period: calendar month Recommended RVW: 1.73

993X3 Care Plan Oversight Services for Patients in the Hospice Setting; 30 minutes or more.

CLINICAL DESCRIPTION OF SERVICE:

Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more.

Vignette Used in Survey:

First month of terminal home care of 58 year old woman with very advanced intraabdominal ovarian cancer requiring IV pain management with management of nausea and emesis intermittently, altered mentation with restlessness, bowel management problems, intercurrent urinary infection and electrolyte disturbances from higher dose diuretics. Extensive calls with family, MSW, nursing to discuss management and supportive counseling. Home visit to patient planned. Extensive documentation includes review and modification of care plan and certifications from nursing, MSW, pharmacy and DME. Approximate physician time of service is 45 minutes, not counting staff time to file lab orders, prescriptions and handling forms.

SURVEY DATA:

Specialty: Internal Medicine (ASIM) and Family Medicine (AAFP)

Sample Size: 25/174 Response Rate (%): 14.4% Median RVW: 1.73

25th Percentile RVW: 1.4 75th Percentile RVW: 2.12 Low: 1.1 High: 3.0

Median Pre-Service Time: 10 minutes Median Intra-Service Time: 38 minutes

25th Percentile Intra-Svc Time: 30 minutes 75th Percentile Intra-Svc Time: 45 minutes

Low Intra-Svc Time: 0 minutes High Intra-Svc Time: 120 minutes

Median Post-Service Time: 10 minutes

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 99215	Established patient outpatient/office visit	1.77
2) 99233	Subsequent hospital care	1.51
3) 99243	Office consultation	1.72

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median M.E.&J.	Median T.S. & P.E.	Median P.S.
993X3(AE5)	10 minutes	38 minutes	10 minutes	4	3	4
99215	5 minutes	40 minutes	10 minutes	4	3	4
99233	5 minutes	30 minutes	11.5 mins	3.5	3	3
99243	8 minutes	40 minutes	8 minutes	4	3	3

ADDITIONAL RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research. _

FREQUENCY INFORMATION

How was this service previously reported? 99375.

How often do physicians in your specialty perform this service? XX Commonly __ Sometimes __ Rarely

Estimate the number of times this service might be provided nationally in a one-year period?
Median responses was 3 times per respondent per year.

Is this service performed by many physicians across the United States? XX Yes __ No

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

CPT Code: 993X4 Tracking Number: (AE6) Global Period: calendar month Recommended RVW: 1.25

993X4 Care Plan Oversight Services for Patients in the Nursing Facility Setting; 15-29 minutes.

CLINICAL DESCRIPTION OF SERVICE:

Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes.

Vignette Used in Survey:

79 year old female who transferred to the nursing facility after treatment of broken hip; was marginally nourished before and now is anorexic, depressed and weak. Anemia, hypokalemia from diuretics are present. NG feeding is initiated and monitored with weekly lab tests, patient status review with nursing personnel, 5 calls from nursing and variety of verbal orders, care plans to review and sign. Phone calls from family are also handled. Approximate physician time is 25 minutes, not counting staff time to file lab orders, prescriptions and handling forms.

SURVEY DATA:

Specialty: Internal Medicine (ASIM) and Family Medicine (AAFP)

Sample Size: 26/174 Response Rate (%): 14.9% Median RVW: 1.25

25th Percentile RVW: 0.9 75th Percentile RVW: 1.40 Low: 0.55 High: 2.12

Median Pre-Service Time: 5 minutes Median Intra-Service Time: 20 minutes

25th Percentile Intra-Svc Time: 15 minutes 75th Percentile Intra-Svc Time: 25 minutes

Low Intra-Svc Time: 0 minutes High Intra-Svc Time: 25 minutes

Median Post-Service Time: 10 minutes

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 99213	Established patient outpatient/office visit	0.67
2) 99214	Established patient outpatient/office visit	1.10
3) 99312	Subsequent nursing facility visit	1.06

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median M.E.&J.	Median T.S. & P.E.	Median P.S.
993X4(AE6)	5 minutes	20 minutes	10 minutes	3	2.5	3
99213	5 minutes	15 minutes	7 minutes	3	3	3
99214	5 minutes	20 minutes	5 minutes	3	4	3
99312	4 minutes	17.5 mins	7.5 minutes	3	2	3

ADDITIONAL RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

FREQUENCY INFORMATION

How was this service previously reported? 99375

How often do physicians in your specialty perform this service XX Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period?
Median response was 20 times per respondent per year.

Is this service performed by many physicians across the United States? XX Yes No

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

CPT Code: 993X5 Tracking Number: (AE7) Global Period: calendar month Recommended RVW: 1.89

993X5 Care Plan Oversight Services for Patients in the Nursing Facility Setting; 30 or more minutes.

CLINICAL DESCRIPTION OF SERVICE:

Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 or more minutes.

Vignette Used in Survey:

84 year old male discharged to the nursing facility from the acute setting after CVA complicating underlying diabetes, hypertension with ASHD, requiring insulin management and Coumadin, after placement of gastric feeding tube. Patient requires frequent Coumadin adjustments the first month and frequent insulin regimen changes as he is adapted to tube feeding and slowly transitioned as oral intake improves. Diarrhea requires assessment and management, an intercurrent UTI and oral candida are managed. Care plan review, numerous phone calls and faxes, verbal orders to sign, lab work to review, phone calls from nurse and family are needed plus charting time; without face to face visit during first month. Physician time is 50 minutes, not counting staff time to file lab orders, prescriptions and handling forms.

SURVEY DATA:

Specialty: Internal Medicine (ASIM) and Family Medicine (AAFP)

Sample Size: 25/174 Response Rate (%): 14.4% Median RVW: 1.89

25th Percentile RVW: 1.44 75th Percentile RVW: 2.5 Low: 1.2 High: 6.42

Median Pre-Service Time: 8.5 minutes Median Intra-Service Time: 36 minutes

25th Percentile Intra-Svc Time: 30 minutes 75th Percentile Intra-Svc Time: 50 minutes

Low Intra-Svc Time: 0 minutes High Intra-Svc Time: 50 minutes Median Post-Service Time: 10 minutes

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 99222	Initial hospital care	2.14
2) 99215	Established patient outpatient/office visit	1.77

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median M.E.&J.	Median T.S. & P.E.	Median P.S.
993X5(AE7)	8.5 minutes	36 minutes	10 minutes	4	3	4
99222	10 minutes	40 minutes	10 minutes	3	3	3
99215	5 minutes	37.5 mins	10 minutes	4	3	3

ADDITIONAL RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

FREQUENCY INFORMATION

How was this service previously reported? -99375

How often do physicians in your specialty perform this service? XX Commonly ___ Sometimes ___ Rarely

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

Median response was 10 times per respondent per year.

Is this service performed by many physicians across the United States? XX Yes ___ No

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Nursing Facility Discharge - Tab 19

A proposal submitted by specialty societies was considered at the February 1997 CPT Editorial Panel Meeting. This proposal was developed because the current discharge code inadequately describe discharge services from facilities other than the hospital and the subsequent nursing facility care codes inadequately describe the work involved with a discharge service. The Panel approved two new nursing facility discharge codes contingent upon the development of appropriate texts and cross-references.

The specialty societies reported to the RUC that the nursing facility discharge day management codes are to be used to report the total duration of time spent by the physician for the final nursing facility discharge of the patient. The codes include as appropriate, final examination of the patient, discussion of the nursing facility stay, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms. The specialty societies also reported that these codes represent a culmination of all the activities associated with the discharge of the patient.

The RUC agreed that RVUs based on the 25th percentile of the survey results would be a more appropriate recommendation. In addition, in order to prevent the inappropriate use of these codes (eg., signing death certificates etc.), the RUC agreed that the time in the descriptor of CPT code 99315 be changed from "30 minutes or less" to "15 -29 minutes."

Code	Intra-Service Time	RUC Recommendation
99315	15	1.20
99316	30	1.60

The RUC agreed that there is less physician work involved in nursing facility than hospital discharge. In addition, the RUC lowered the RVU recommendation proposed by the facilitation committee on code 99316 from 1.74 to 1.60 RVUs, the above table reflects those changes. The recommendation of 1.20 RVUs for code 99315 and 1.60 RVUs for code 99316 represents approximately 10 % less work than the RVUs for the hospital discharge codes 99238, 1.28 RVUs and 99239, 1.75 RVUs respectively.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Nursing Facility Services (p. 29, CPT 1997) Comprehensive Nursing Facility Assessments New or Established Patient <p><i>When the patient is admitted to the nursing facility in the course of an encounter in another site of service (eg, hospital emergency department, physician's office), all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial nursing facility care when performed on the same date as part of the admission or readmission. The nursing facility care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the nursing facility setting. With the exception of hospital discharge services, evaluation and management services on the same date provided in sites other than the nursing facility that are related to the admission should NOT be reported separately.</i></p> <p>Hospital discharge services may be reported separately. Hospital inpatient or observation discharge services performed on the same date of nursing facility admission or readmission may be reported separately. For a patient discharged from inpatient status on the same date of nursing facility admission or readmission, the hospital discharge services should be reported with codes 99238-99239 as appropriate. For a patient discharged from observation status on the same date of nursing facility admission or readmission, the observation care discharge services should be reported with code 99217. For a patient admitted and discharged from observation or inpatient status on the same date, see codes 99234-99236.</p> <p>For nursing facility care discharge, see 99315, 99316)</p> <p>More than one comprehensive assessment may be necessary during an inpatient confinement.</p> <u>Nursing Facility Discharge Services</u> <p><u>The nursing facility discharge day management codes are to be used to report the total duration of time spent by a physician for the final nursing facility discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the nursing facility stay, even if the time spent by the physician on that date is not continuous. Instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms.</u></p>				

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•99315	AF1	Nursing facility discharge day management; 30 minutes or less	XXX	1.20
•99316	AF2	more than 30 minutes	XXX	1.60

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 993X1 Tracking Number: (AF1) Global Period: XXX Recommended RVW: 1.28

993X1 Nursing Facility Discharge Day Management; 30 minutes or less.

CLINICAL DESCRIPTION OF SERVICE:

The nursing facility discharge day management codes are to be used to report the total duration of time spent by a physician for the final nursing facility discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the nursing facility stay, even if the time spent by the physician on that date is not continuous. Instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms.

Vignette Used in Survey:

Final nursing facility day for a 72 year old female with community acquired pneumonia who spent 2 days at acute level and then transferred to skilled nursing unit with need for continued IV antibiotic, breathing treatments and inability to care for herself. She is improving and able to switch to oral antibiotics. Discharge history and exam are problem focused, medical decision making straight forward and patient requires a written prescription for antibiotic and simple instructions for medication, follow up and complications to be alert to. Brief chart note and short written or dictated discharge summary is prepared. Approximate physician time of service is 20 minutes.

SURVEY DATA:

Specialty: Internal Medicine (ASIM) and Nursing Home Medical Directors (AMDA)

Sample Size: 38/157 Response Rate (%): 24.2% Median RVW: 1.28

25th Percentile RVW: 1.2 75th Percentile RVW: 1.38 Low: 0.6 High: 1.71

Median Pre-Service Time: 5 minutes Median Intra-Service Time: 15 minutes

25th Percentile Intra-Svc Time: 10 minutes 75th Percentile Intra-Svc Time: 20 minutes

Low Intra-Svc Time: 0 minutes High Intra-Svc Time: 30 minutes

Median Post-Service Time: 10 minutes

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 99238	Hospital Discharge Day Management, 30 min. or less	1.28
2) 99312	Subsequent nursing facility care	1.06

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median M.E.&J.	Median T.S.&P.E.	Median P.S.
993X1(AF1)	5 minutes	15 minutes	10 minutes	3	3	3
99238	5 minutes	12 minutes	7.5 minutes	3	3	3
99312	10 minutes	25 minutes	5 minutes	3	3	3

ADDITIONAL RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

FREQUENCY INFORMATION

How was this service previously reported? 99312

How often do physicians in your specialty perform this service? XX Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period?
Median response was 20 times per person per year

Is this service performed by many physicians across the United States? XX Yes No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 993X2 Tracking Number: (AF2) Global Period: XXX Recommended RVW: 1.8

993X2 Nursing Facility Discharge Day Management; More than 30 minutes

CLINICAL DESCRIPTION OF SERVICE:

The nursing facility discharge day management codes are to be used to report the total duration of time spent by a physician for the final nursing facility discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the nursing facility stay, even if the time spent by the physician on that date is not continuous. Instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms.

Vignette Used in Survey:

Final nursing facility day for 84 year old male who entered the nursing facility after suffering a CVA with hemiparesis, complicating diabetes which now requires insulin management, hypertension and prior MI with prior CHF. Feeding gastrostomy was placed. Discharge day history & exam are extended to verify all systems are stable, and medical decision making is moderate. Home health agency and family will be involved with home care with PT, OT visits and periodic nursing assessments. Multiple medications and insulin instructions are prescribed. Prescriptions must be phoned to local pharmacy and separate written prescriptions prepared for mail-away pharmacy. The home health agency referral sheet, discharge note, lengthy discharge summary, instructions to floor nursing, complex verbal & written instructions to family are prepared. Approximate physician time of service is 50 minutes.

SURVEY DATA:

Specialty: Internal Medicine (ASIM) and Nursing Home Medical Directors (AMDA)

Sample Size: 37/157 Response Rate (%): 23.6% Median RVW: 1.8

25th Percentile RVW: 1.74 75th Percentile RVW: 2.2 Low: 1.16 High: 3.5

Median Pre-Service Time: 10 minutes Median Intra-Service Time: 30 minutes

25th Percentile Intra-Svc Time: 15 minutes 75th Percentile Intra-Svc Time: 40 minutes

Low Intra-Svc Time: 0 minutes High Intra-Svc Time: 60 minutes

Median Post-Service Time: 15 minutes

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1) 99239	Hospital discharge day management, more than 30 min.	1.75
2) 99303	Nursing facility care	2.14
3) 99313	Subsequent nursing facility care	1.51
4) 99215	Established patient outpatient/office visit	1.77

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median M.E.&J.	Median T.S.&P.E.	Median P.S.
993X1(AF2)	10 minutes	30 minutes	15 minutes	4	4	4
99239	10 minutes	17.5 min.	15 minutes	3.5	4	4
99303	10 minutes	30 minutes	15 minutes	4	4	4
99313	5 minutes	32.5 min.	32.5 min.	4	4	3.5
99215	10 minutes	30 minutes	15 minutes	4	4	4

ADDITIONAL RATIONALE

Provide a detailed rationale for your recommendation, including a description of all applicable elements of work: time; technical skill & physical effort; mental effort and judgement; and stress. Attach any objective data that will support your rationale, including materials you received from the AMA or your own research.

FREQUENCY INFORMATION

How was this service previously reported? 99313

How often do physicians in your specialty perform this service XX Commonly Sometimes Rarely

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

Median response was 12 times per respondent per year

Is this service performed by many physicians across the United States? XX Yes No

American Medical Association

Physicians dedicated to the health of America



James G. Hoehn, MD
Chairman
AMA/Specialty Society RVS
Update Committee

515 North State Street
Chicago, Illinois 60610

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October 10, 1997

Bart C. McCann, MD
Executive Medical Officer
Plan and Provider Purchasing Policy Group
Health Care Financing Administration, C4-03-03
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Doctor McCann:

As you know, the RUC adopted relative value recommendations on home visit services last April. The RUC accepted the recommendations based on the following assumptions:

1. At the April RUC meeting, the RUC based its recommendations on intra-service time from the RUC survey. Subsequently, these recommendations changed to reflect the CPT intra-service time adopted at the May 1997 CPT Editorial Panel meeting. As we understand it, these CPT times took into consideration the RUC survey and a survey of the vignettes only.
2. The RUC assumed the same intra-service intensity (.031) for the home visits services that was assigned to the office visit services by HCFA during the five-year review of the RBRVS.
3. The RUC assumed that home and office visit services have similar pre and post service work and used the same multiplier of 1.43 to calculate the total work relative value for these services.

On September 3, 1997 the American Academy of Home Care Physicians (AACHP) requested a reconsideration of the RUC recommendations for the home visit services. In their letter the AACHP argued that the work involved the provision of a home visit is more intense and that the IWP/UT should be .032. They also argued that there is additional pre and post service work involved in the provision of a home visit and suggested that the RUC use a multiplier of 1.54.

I appointed a facilitation committee to examine this issue and report their findings to the RUC in San Diego. In their report to the RUC, the facilitation committee did not believe that there was compelling evidence to support the AACHP contention that home visit services require more work than office visits, in either intra-service intensity or in the amount of pre and post service work that is involved. However, the facilitation committee did express their concern to the RUC regarding the reduction of the April RUC recommendations for these services due to the decreased intra-service time assigned by CPT. The Facilitation committee believed that the RUC survey intra-service time was accurate and recommended that the RUC reaffirm the relative value recommendations from April. These recommendations are as follows:

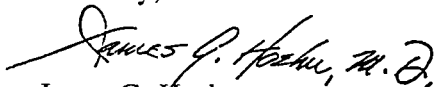
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Bart McCann
October 10, 1997
Page 2

CPT Code	Intra-service Time	RUC Recommendation (Intra-service time x IWPUT of .031 x 1.43)
New Patient		
99341	20	0.89
99342	30	1.33
99343	50	2.22
99344	60	2.66
99345	90	3.75
Established Patient		
99347	15	0.66
99348	30	1.33
99349	40	1.77
99350	72.5	3.21

If this recommendation is too late to consider for the November, 1997 Final Rule, please consider it during the comment period. Thank you for your consideration of this matter.

Sincerely,


James G. Hoehn

cc: Peter Boling, MD

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Home Care Visits - Tab 20

At the April 1996 RUC meeting, the RUC adopted a recommendation that the entire family of home visit codes be referred to the CPT Editorial Panel to consider the following issues:

1. The highest level of service in the current new and established patient home services involves only a detailed history and a detailed examination. Therefore, there is no code to identify those home services which involve either a comprehensive history or comprehensive examination.
2. The current home services codes do not reflect the fact that physicians providing home services must often provide extensive education, counseling, and care coordination involving the patient, patient's family or caregiver.

A proposal was submitted by the specialty societies which was considered at the February 1997 CPT Editorial Panel Meeting. The proposal addressed the concerns of the RUC by adding new codes that require a comprehensive history and comprehensive examination as key components. In addition, a sentence was added to the descriptor of each home visit code which reads: "Education and counseling involving the patient, patient's family or caregiver is also provided." The Panel tentatively accepted new home visit codes and the revision of existing codes contingent on their review of the April 1997 RUC recommendations concerning typical times for these codes.

At the April RUC meeting, the specialty societies reported that a home care service is an evaluation and management service provided to a new or established patient in the home. The level of service provided depends on the history, examination, and medical decision making involved. The presenters noted that the home care visit patient population is more complex than patients seen by physicians in the office setting. It was also reported that the home care codes were never surveyed by Harvard and that the relative value units were assigned by HCFA. In addition, the specialties noted that office visit post-service time is an inappropriate point of comparison since home health patients are only seen by the physician when they are ill.

The RUC was informed that HCFA would consider a level degree of intensity for this family of codes. This was based on the revised intra-service work intensities that resulted from HCFA's review of the RUC recommendations from the 5-year review of the evaluation and management services. As described in the May 3, 1996 NPRM; pre-service and post-service work is expressed as a percentage of intra-service work. *In order to calculate the new RVUs for the office visit codes for new and established patients, HCFA used intra-service work intensities and pre- and post-service work percentages in addition to the CPT times for each code. The intra-service work intensity of 0.031 was multiplied by the typical time of the code to determine new intra-service work values. The pre-and post-service work of this value was added to the intra-service work value to calculate the final*

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work RVUs for these codes. The formula is $\text{total work RVUs} = (\text{intra-service work intensity}) \times (\text{CPT time}) \times (1 + \text{pre/post percentage of intra-service work})$.

The pre/post percentage of intra-service work was calculated to be 43% in 1997 for the office visit codes. These assumptions were applied in developing the RUC recommendations for home visits.

The home visit recommendations were accepted by the full RUC contingent on the CPT Editorial Panel inserting all of the RUC intra-service times into the CPT descriptors of the codes. The CPT Panel reviewed this issue at their May 2, 1997 meeting and agreed to include the intra-service times that were originally proposed by the specialty society. These times were validated by combining the results of both the RUC survey and a survey of vignettes only conducted for CPT. The CPT times vary from the time presented at the RUC meeting for four codes. The intra-service times and the calculated RUC recommendations are listed below:

Code	Intra-service Time (To be published in <u>CPT</u> <u>1998</u>)	RUC Recommendation (Intra-service time x IWPUT of 0.031)
99341	20	0.89
99342	30	1.33
99343	45	1.99
99344	60	2.66
99345	75	3.32
99347	15	0.66
99348	25	1.11
99349	40	1.77
99350	60	2.66

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
99341	AG1	<p>Home visit for the evaluation and management of a new patient, which requires these three key components:</p> <ul style="list-style-type: none"> • a problem focused history; • a problem focused examination; and • <u>straightforward</u> medical decision making that is of low complexity. <p>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.</p> <p>Usually, the presenting problem(s) are of low severity. <u>Physicians typically spend 20 minutes face-to-face with the patient and/or family.</u></p>	XXX	0.89
99342	AG2	<p>Home visit for the evaluation and management of a new patient, which requires these three key components:</p> <ul style="list-style-type: none"> • an expanded problem focused history; • an expanded problem focused examination; and • medical decision making of moderate <u>low</u> complexity. <p>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.</p> <p>Usually, the presenting problem(s) are of moderate severity. <u>Physicians typically spend 30 minutes face-to-face with the patient and/or family.</u></p>	XXX	1.33
99343	AG3	<p>Home visit for the evaluation and management of a new patient, which requires these three key components:</p> <ul style="list-style-type: none"> • a detailed history; • a detailed examination; and • medical decision making of high <u>moderate</u> complexity. <p>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.</p> <p>Usually, the presenting problem(s) are of <u>moderate to high</u> severity. <u>Physicians typically spend 45 minutes face-to-face with the patient and/or family.</u></p>	XXX	1.99

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•99344	AG4	<p>Home visit for the evaluation and management of a new patient, which requires these three key components:</p> <ul style="list-style-type: none"> • a comprehensive history; • a comprehensive examination; and • medical decision making of moderate complexity. <p>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.</p> <p>Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.</p>	XXX	2.66
•99345	AG5	<p>Home visit for the evaluation and management of a new patient, which requires these three key components:</p> <ul style="list-style-type: none"> • a comprehensive history; • a comprehensive examination; and • medical decision making of high complexity. <p>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.</p> <p>Usually the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend [75] minutes face-to-face with the patient and/or family.</p>	XXX	3.32
•99347	AG6	<p>Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> • a problem focused interval history; • a problem focused examination; • straightforward medical decision making <p>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.</p> <p>Usually the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.</p>	XXX	0.66

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•99348	AG7	<p>Home visit for the evaluation and management of an established patient, which requires these three key components:</p> <ul style="list-style-type: none"> • an expanded problem focused interval history; • an expanded problem focused examination; • medical decision making of low complexity. <p>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.</p> <p>Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.</p>	XXX	1.11
•99349	AG8	<p>Home visit for the evaluation and management of an established patient, which requires these three key components:</p> <ul style="list-style-type: none"> • a detailed interval history; • a detailed examination; • medical decision making of high complexity. <p>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.</p> <p>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.</p>	XXX	1.77
•99350	AG9	<p>Home visit for the evaluation and management of an established patient, which requires these three key components:</p> <ul style="list-style-type: none"> • a comprehensive interval history; • a comprehensive examination; and • medical decision making of moderate to high complexity. <p>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.</p> <p>Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem that may require immediate physician attention otherwise provided in an emergency department. Physicians typically spend [60] minutes face-to-face with the patient and/or family.</p>	XXX	2.66

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
99351	AG6	<p>Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> • a problem focused interval history; • a problem focused examination; • medical decision making that is of low complexity. <p>Counseling and/or coordination of care with other providers or agencies</p> <p>Usually, the patient is stable, recovering or improving (99351 has been deleted. To report, see 99347)</p>	XXX	N/A
99352	AG7	<p>Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> • an expanded problem focused interval history; • an expanded problem focused examination; • medical decision making of moderate complexity. <p>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</p> <p>Usually, the patient is responding inadequately to therapy or has developed a minor complication (99352 has been deleted. To report, see 99348)</p>	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
99353	AG8	<p>Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> • a detailed interval history; • a detailed examination; • medical decision making of high complexity. <p>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.</p> <p>Usually, the patient is unstable or has developed a significant complication or a significant new problem</p> <p>(99353 has been deleted. To report, see 99349)</p>	XXX	N/A

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

CPT Code: 99341 Tracking Number: AG1 Global Period: XXX Recommended RVW: 1.00

CPT Descriptor:

Home visit for the evaluation and management of a new patient which requires these three key components:

- a problem focused history,
- a problem focused examination; and
- straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low severity. Physicians typically spend [] minutes face-to-face with the patient and/or family.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

81 year old male new patient referred for home care because advanced osteoarthritis of the knees and hips has rendered him wheelchair bound. Specialty transport to the office is financially difficult. His physician will not refill his prescriptions over the phone, not having seen the patient for 2 years. Other problems are painful bunions and onychomycosis. [family practice and home care]

Home visit for a new 85 year-old patient with Alzheimer's dementia who has developed a pruritic skin eruption on both feet with no apparent complication. [podiatry]

9 year old male new patient referred to home care with severe spastic cerebral palsy. Requires renewal of seizure medication. No recent change in seizure incidence but his physician will not refill his prescription over the phone, not having seen the patient for 2 years. Specialty transport to office financially difficult. [pediatrics]

Description of Pre-Service Work:

The pre-service period includes services that are not performed at the patient's home, including: communications with other professionals and the patient and/or family; obtaining and/or reviewing written records, telephone reports, and the results of diagnostic and other studies.

Description of Intra-Service Work:

The intra-service period includes the services provided while you are with the patient and/or family in the patient's home. This includes the time in which the physician completes the history and physical examination, including evaluation of the patient's functional status, the environment and the caregiver's understanding and ability to provide the needed care. Additional "bundled" services such as drawing blood are part of intra-service work. Counseling the patient and/or family and communicating with other professionals from the patient's home are also included.

Description of Post-Service Work:

The post-service period includes services that are not provided at the patient's home such as: arranging for further services and coordination of care, reviewing results of studies, and communicating further with the patient, family, and other professionals including written and telephone reports. Post-service work associated with the house call cannot be counted toward care plan oversight (G0064) if that code is to be billed.

SURVEY DATA:

Specialty: Home Care, Family Practice, Podiatry, and Pediatrics

Sample Size: 64/360 Response Rate (%): 18% Median RVW: 1.00

25th Percentile RVW: 0.80 75th Percentile RVW: 1.30 Low: 0.25 High: 3.00

Median Pre-Service Time: 6.5 minutes Median Intra-Service Time: 20 minutes

25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 30 Low: 10 High: 60

Median Post-Service Time: 10 minutes

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99241	Office Consultation	0.64
2)			
3)			
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
99341	6.5	20	10	3	2	2
99241	3	15	7	2	2	2

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? 99341

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 520,000+ (based on median survey response and number of physicians in specialties)

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 99342 Tracking Number: AG2 Global Period: XXX Recommended RVW: 1.60

CPT Descriptor:

Home visit for the evaluation and management of a new patient which requires these three key components:

- an expanded problem focused history;
- an expanded problem focused 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 [] minutes face-to-face with the patient and/or family.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

80 year old female new patient who is hemiplegic and chairbound after a stroke. She has stable hypertension on two medications with a blood pressure of 146/88 and no evidence of heart failure. She is cared for by her sisters. Her previous physician died some time ago, and you are being asked to assume her care. [family practice and home care]

Home visit for a new 78 year-old patient with moderate dementia and peripheral vascular disease affecting both lower extremities who has a recurring painful infected ingrown toenail. [podiatry]

14 year old female new patient who is wheelchair-dependent quadriplegic at home for several years after automobile accident. Currently normotensive with rare mass reflexes. Previous physician managed autonomic nervous system instability and frequent mass reflex responses at home. You are being asked to assume her care. [pediatrics]

Description of Pre-Service Work:

The pre-service period includes services that are not performed at the patient's home, including: communications with other professionals and the patient and/or family; obtaining and/or reviewing written records, telephone reports, and the results of diagnostic and other studies.

Description of Intra-Service Work:

The intra-service period includes the services provided while you are with the patient and/or family in the patient's home. This includes the time in which the physician completes the history and physical examination, including evaluation of the patient's functional status, the environment and the caregiver's understanding and ability to provide the needed care. Additional "bundled" services such as drawing blood are part of intra-service work. Counseling the patient and/or family and communicating with other professionals from the patient's home are also included.

Description of Post-Service Work:

The post-service period includes services that are not provided at the patient's home such as: arranging for further services and coordination of care, reviewing results of studies, and communicating further with the patient, family, and other professionals including written and telephone reports. Post-service work associated with the house call cannot be counted toward care plan oversight (G0064) if that code is to be billed.

SURVEY DATA:

Specialty: Home Care, Family Practice, Podiatry, and Pediatrics

Sample Size: 65/360 Response Rate (%): 18% Median RVW: 1.60

25th Percentile RVW: 1.36 75th Percentile RVW: 2.00 Low: 0.64 High: 3.50

Median Pre-Service Time: 10 minutes Median Intra-Service Time: 30 minutes

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 40 Low: 6 High: 80

Median Post-Service Time: 12 minutes

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99242	Office Consultation	1.29
2)			
3)			
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
99342	10	30	12	3	3	3
99242	5	30	5	2	2	2

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? 99341

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 572,000+ (based on median survey response and number of physicians in specialties)

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 99343 Tracking Number: AG3 Global Period: XXX Recommended RVW: 2.50

CPT Descriptor:

Home visit for the evaluation and management of a new patient which requires these three key components:

- a detailed history;
- a detailed examination; and
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the 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 [] minutes face-to-face with the patient and/or family.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

75 year old female new patient who has had three hospitalizations in the past 6 months for heart failure despite active home health agency nursing care. She has Class III heart failure with exertional dyspnea, orthopnea, edema, and mild renal insufficiency. She has not kept doctor's appointments due to immobility and urinary incontinence. Her daughter works days and cannot assist her mother to the physician's office. She asks the physician to call her at work during the home visit. [family practice and home care]

Home visit for a new 77 year-old type I diabetic female patient with recent aortic valve replacement, and carotid endarterectomy with grade 2 skin ulcer on the plantar aspect of her right foot. The patient is taking coumadin and has concomitant lower extremity peripheral vascular disease and peripheral neuropathy. [podiatry]

12 year old female new patient who has had three acute hospitalizations in the past 6 months for status asthmaticus despite office visits and active home health agency nursing care. She has chronic wheezing despite home aerosol therapy and high-dose oral steroids. She has significant school absenteeism and physician has been asked to evaluate patient in home environment and call school authorities with recommendations. [pediatrics]

Description of Pre-Service Work:

The pre-service period includes services that are not performed at the patient's home, including: communications with other professionals and the patient and/or family; obtaining and/or reviewing written records, telephone reports, and the results of diagnostic and other studies.

Description of Intra-Service Work:

The intra-service period includes the services provided while you are with the patient and/or family in the patient's home. This includes the time in which the physician completes the history and physical examination, including evaluation of the patient's functional status, the environment and the caregiver's understanding and ability to provide the needed care. Additional "bundled" services such as drawing blood are part of intra-service work. Counseling the patient and/or family and communicating with other professionals from the patient's home are also included.

Description of Post-Service Work:

The post-service period includes services that are not provided at the patient's home such as: arranging for further services and coordination of care, reviewing results of studies, and communicating further with the patient, family, and other professionals including written and telephone reports. Post-service work associated with the house call cannot be counted toward care plan oversight (G0064) if that code is to be billed.

SURVEY DATA:

Specialty: Home Care, Family Practice, Podiatry, and Pediatrics

Sample Size: 65/360 Response Rate (%): 18% Median RVW: 2.50

25th Percentile RVW: 2.00 75th Percentile RVW: 3.00 Low: 1.25 High: 4.00

Median Pre-Service Time: 15 minutes Median Intra-Service Time: 50 minutes

25th Percentile Intra-Svc Time: 40 75th Percentile Intra-Svc Time: 60 Low: 20 High: 90

Median Post-Service Time: 17 minutes

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99243	Office Consultation	1.72
2)			
3)			
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
99343	15	50	17	4	4	4
99243	5	40	10	3	3	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? 99342

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1,040,000+ (based on median survey response and number of physicians in specialties)

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 993X1 Tracking Number: AG4 Global Period: XXX Recommended RVW: 3.10

CPT Descriptor:

Home visit for the evaluation and management of a new patient which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of high severity. Physicians typically spend [] minutes face-to-face with the patient and/or family.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

73 year old female new patient who has had weight loss, social withdrawal and progressive agitation over the past 2 months. She refuses to leave the home for evaluation. Her caregiver is exhausted and emotionally drained. The patient has been followed through telephonic conversations by a primary care physician who has been ordering psychotropic medications to control behavior, and a cardiologist for ischemic heart disease for which she takes four medications, but she has seen neither of them for over a year. [family practice and home care]

8 month old male infant new patient at home with broncho pulmonary dysplasia requiring long term oxygen and cardiopulmonary monitoring. Actively followed by home health nursing who calls physician for evaluation of poor growth, increasing incidence of intermittent wheezing, and more frequent oxygen denaturation during nippy feeding over past few months. Parents have been up many nights and are emotionally exhausted. [pediatrics]

Description of Pre-Service Work:

The pre-service period includes services that are not performed at the patient's home, including: communications with other professionals and the patient and/or family; obtaining and/or reviewing written records, telephone reports, and the results of diagnostic and other studies.

Description of Intra-Service Work:

The intra-service period includes the services provided while you are with the patient and/or family in the patient's home. This includes the time in which the physician completes the history and physical examination, including evaluation of the patient's functional status, the environment and the caregiver's understanding and ability to provide the needed care. Additional "bundled" services such as drawing blood are part of intra-service work. Counseling the patient and/or family and communicating with other professionals from the patient's home are also included.

Description of Post-Service Work:

The post-service period includes services that are not provided at the patient's home such as: arranging for further services and coordination of care, reviewing results of studies, and communicating further with the patient, family, and other professionals including written and telephone reports. Post-service work associated with the house call cannot be counted toward care plan oversight (G0064) if that code is to be billed.

SURVEY DATA:

Specialty: Home Care, Family Practice, and Pediatrics

Sample Size: 58/270 Response Rate (%): 21% Median RVW: 3.10

25th Percentile RVW: 2.80 75th Percentile RVW: 3.50 Low: 2.00 High: 5.88

Median Pre-Service Time: 15 minutes Median Intra-Service Time: 60 minutes

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 75 Low: 20 High: 120

Median Post-Service Time: 25 minutes

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99244	Office Consultation	2.58
2)			
3)			
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
993X1	15	60	25	4	4	4
99244	8	60	15	4	3	4

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? 99342

How often do physicians in your specialty perform this service? X Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1,040,000+ (based on median survey response and number of physicians in specialties)

Is this service performed by many physicians across the United States? X Yes No

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

CPT Code: 993X2 Tracking Number: AG5 Global Period: XXX Recommended RVW: 3.75

CPT Descriptor:

Home visit for the evaluation and management of a new patient which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend [] minutes face-to-face with the patient and/or family.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

83 year old male new patient who was followed at home by a recently retired physician for multi-infarct dementia, diabetes mellitus, and osteoarthritis of the back, hip, and knee. He now has a fever of 101.5, cough, chest congestion, rapid respirations, marked decline in mental alertness, and cloudy urine. Oral intake has dropped sharply for the past 2 days. His family does not want him to be hospitalized but wants to take all available measures to help him recover at home. [family practice and home care]

12 year old female new patient at home with chronic respiratory insufficiency due to neuromuscular weakness from myopathy requiring prolonged mechanical ventilation and long term oxygen. One day history of severe vomiting and diarrhea and reduced oral intake. Parents very capable of home care and want to avoid hospitalization. They call physician due to significant reduced urine input. Request home evaluation for hydration status but regular physician on vacation. [pediatrics]

Description of Pre-Service Work:

The pre-service period includes services that are not performed at the patient's home, including: communications with other professionals and the patient and/or family, obtaining and/or reviewing written records, telephone reports, and the results of diagnostic and other studies.

Description of Intra-Service Work:

The intra-service period includes the services provided while you are with the patient and/or family in the patient's home. This includes the time in which the physician completes the history and physical examination, including evaluation of the patient's functional status, the environment and the caregiver's understanding and ability to provide the needed care. Additional "bundled" services such as drawing blood are part of intra-service work. Counseling the patient and/or family and communicating with other professionals from the patient's home are also included.

Description of Post-Service Work:

The post-service period includes services that are not provided at the patient's home such as: arranging for further services and coordination of care, reviewing results of studies, and communicating further with the patient, family, and other professionals including written and telephone reports. Post-service work associated with the house call cannot be counted toward care plan oversight (G0064) if that code is to be billed.

SURVEY DATA:

Specialty: Home Care, Family Practice, and Pediatrics

Sample Size: 58/270 Response Rate (%): 21% Median RVW: 3.75

25th Percentile RVW: 3.50 75th Percentile RVW: 4.00 Low: 2.20 High: 7.30

Median Pre-Service Time: 15 minutes Median Intra-Service Time: 90 minutes

25th Percentile Intra-Svc Time: 62.5 75th Percentile Intra-Svc Time: 90 Low: 30 High: 120

Median Post-Service Time: 30 minutes

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99245	Office Consultation	3.43
2)			
3)			
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
993X2	15	90	30	5	4	5
99245	8	80	15	4	4	4

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? 99343

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 520,000+ (based on median survey response and number of physicians in specialties)

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 99351 Tracking Number: AG6 Global Period: XXX Recommended RVW: 0.80

CPT Descriptor:

Home visit for the evaluation and management of an established patient which requires at least two of these three 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 presenting problem(s) are self-limited or minor. Physicians typically spend [] minutes face-to-face with the patient and/or family.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

87 year old female established patient who has received regular care for probable Alzheimer's type dementia. The caregiver also complains about calluses, long toenails and onychomycosis that interfere with walking. The patient is calm when seen at home but she becomes agitated and disruptive if brought to the office. [family practice and home care]

Home visit for an established 76 year-old patient with Alzheimer's dementia who has been improving with antifungal treatment for a dermatophyte infection of both feet with no apparent complications. [podiatry]

8 year old male established patient with severe developmental disability with frequent pneumonia requiring hospitalization and being considered for long term oral antibiotic management. Patient becomes extremely agitated during office visits but can be easily evaluated by physician while at play on the floor at home. [pediatrics]

Description of Pre-Service Work:

The pre-service period includes services that are not performed at the patient's home, including: communications with other professionals and the patient and/or family; obtaining and/or reviewing written records, telephone reports, and the results of diagnostic and other studies.

Description of Intra-Service Work:

The intra-service period includes the services provided while you are with the patient and/or family in the patient's home. This includes the time in which the physician completes the history and physical examination, including evaluation of the patient's functional status, the environment and the caregiver's understanding and ability to provide the needed care. Additional "bundled" services such as drawing blood are part of intra-service work. Counseling the patient and/or family and communicating with other professionals from the patient's home are also included.

Description of Post-Service Work:

The post-service period includes services that are not provided at the patient's home such as: arranging for further services and coordination of care, reviewing results of studies, and communicating further with the patient, family, and other professionals including written and telephone reports. Post-service work associated with the house call cannot be counted toward care plan oversight (G0064) if that code is to be billed.

SURVEY DATA:

Specialty: Home Care, Family Practice, Podiatry, and Pediatrics

Sample Size: 65/360 Response Rate (%): 18% Median RVW: 0.80

25th Percentile RVW: 0.64 75th Percentile RVW: 1.14 Low: 0.25 High: 5.00

Median Pre-Service Time: 5 minutes Median Intra-Service Time: 15 minutes

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 20 Low: 8 High: 60

Median Post-Service Time: 10 minutes

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99241	Office Consultation	0.64
2)	99212	Office Visit, Established Patient	0.45
3)			
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
99351	5	15	10	3	2	2
99212	5	10	5	2	2	2
99241	3	15	5	2	2	1

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? 99351

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1,040,000+ (based on median survey response and number of physicians in specialties)

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 99352 Tracking Number: AG7 Global Period: XXX Recommended RVW: 1.40

CPT Descriptor:

Home visit for the evaluation and management of an established 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 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 low severity. Physicians typically spend [] minutes face-to-face with the patient and/or family.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

53 year old male established patient with debilitating multiple sclerosis who has gradually become wheelchair bound due to inability to bear weight on his legs, and is incontinent of urine. His wife has resumed work in the daytime but provides assistance with activities of daily living in the evening. [family practice and home care]

Home visit for an established 79 year-old post CVA, type I diabetic female patient with concomitant peripheral vascular disease who has been taking antibiotics for an abscess of the right fourth digital interspace for ten days. She has experienced increased pain and swelling during the past 48 hours. She has also noticed red streaks extending towards her leg. [podiatry]

9 month old female established patient at home on parenteral nutrition due to short bowel syndrome resulting from bowel resection required for necrotizing enterocolitis as newborn. Despite frequent home health agency visits, has had poor growth and parents are discouraged and exhausted due to recent increased irritability. Home health agency nurse requests home visits for evaluation of nutrition status, management, and parent counseling. [pediatrics]

Description of Pre-Service Work:

The pre-service period includes services that are not performed at the patient's home, including: communications with other professionals and the patient and/or family, obtaining and/or reviewing written records, telephone reports, and the results of diagnostic and other studies.

Description of Intra-Service Work:

The intra-service period includes the services provided while you are with the patient and/or family in the patient's home. This includes the time in which the physician completes the history and physical examination, including evaluation of the patient's functional status, the environment and the caregiver's understanding and ability to provide the needed care. Additional "bundled" services such as drawing blood are part of intra-service work. Counseling the patient and/or family and communicating with other professionals from the patient's home are also included.

Description of Post-Service Work:

The post-service period includes services that are not provided at the patient's home such as: arranging for further services and coordination of care, reviewing results of studies, and communicating further with the patient, family, and other professionals including written and telephone reports. Post-service work associated with the house call cannot be counted toward care plan oversight (G0064) if that code is to be billed.

SURVEY DATA:

Specialty: Home Care, Family Practice, Podiatry, and Pediatrics

Sample Size: 65/360 Response Rate (%): 18% Median RVW: 1.40

25th Percentile RVW: 1.12 75th Percentile RVW: 1.85 Low: 0.67 High: 4.19

Median Pre-Service Time: 9 minutes Median Intra-Service Time: 30 minutes

25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 35 Low: 3 High: 80

Median Post-Service Time: 10 minutes

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99242	Office Consultation	1.29
2)	99213	Office Visit, Established Patient	0.67
3)			
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
99352	9	30	10	3	3	3
99213	3	15	5	3	3	2
99242	5	30	5	2	2	2

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? 99351 or 99352

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 832,000+ (based on median survey response and number of physicians in specialties)

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 99353 Tracking Number: AG8 Global Period: XXX Recommended RVW: 2.00

CPT Descriptor:

Home visit for the evaluation and management of an established patient which requires at least two of these three key components:

- a detailed interval history;
- a detailed examination;
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend [] minutes face-to-face with the patient and/or family.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

78 year old male established patient treated with insulin for diabetes mellitus who has peripheral vascular disease and stable dyspnea from chronic obstructive pulmonary disease requiring continuous home oxygen. He is becoming progressively less mobile and more dependent on his elderly wife for assistance with transfers and bathing. He complains of increasing left leg pain. [family practice and home care]

4 year old female established patient at home on long term oxygen and prolonged mechanical ventilation ever since birth due to restrictive lung disease (chest wall deformities surgically corrected as a neonate) and severe residual bronchopulmonary dysplasia. Requires 24 hour private duty nursing since both parents work full time with frequent overtime. Physician visit at home with entire home care team (nurses, therapists, parents, and representatives from school, nursing agency, and DME) required to reevaluate home care plan based on medical necessity. [pediatrics]

Description of Pre-Service Work:

The pre-service period includes services that are not performed at the patient's home, including: communications with other professionals and the patient and/or family; obtaining and/or reviewing written records, telephone reports, and the results of diagnostic and other studies.

Description of Intra-Service Work:

The intra-service period includes the services provided while you are with the patient and/or family in the patient's home. This includes the time in which the physician completes the history and physical examination, including evaluation of the patient's functional status, the environment and the caregiver's understanding and ability to provide the needed care. Additional "bundled" services such as drawing blood are part of intra-service work. Counseling the patient and/or family and communicating with other professionals from the patient's home are also included.

Description of Post-Service Work:

The post-service period includes services that are not provided at the patient's home such as: arranging for further services and coordination of care, reviewing results of studies, and communicating further with the patient, family, and other professionals including written and telephone reports. Post-service work associated with the house call cannot be counted toward care plan oversight (G0064) if that code is to be billed.

SURVEY DATA:

Specialty: Home Care, Family Practice, and Pediatrics

Sample Size: 58/270 Response Rate (%): 21% Median RVW: 2.00

25th Percentile RVW: 1.70 75th Percentile RVW: 2.68 Low: 1.00 High: 4.50

Median Pre-Service Time: 10 minutes Median Intra-Service Time: 40 minutes

25th Percentile Intra-Svc Time: 31 75th Percentile Intra-Svc Time: 50 Low: 4 High: 90

Median Post-Service Time: 15 minutes

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99243	Office Consultation	1.72
2)	99214	Office Visit, Established Patient	1.10
3)			
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
99353	10	40	15	4	4	4
99214	5	25	12.5	3	3	3
99243	5	40	10	3	3	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? 99352 or 99353

How often do physicians in your specialty perform this service? X Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 2,080,000+ (based on median survey response and number of physicians in specialties)

Is this service performed by many physicians across the United States? X Yes No

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

CPT Code: 993X3 Tracking Number: AG9 Global Period: XXX Recommended RVW: 3.53

CPT Descriptor:

Home visit for the evaluation and management of an established patient which requires at least two of these three key components:

- a comprehensive interval history;
- a comprehensive examination;
- medical decision making of moderate to 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. The patient may be unstable or may have developed a significant new problem that may require immediate physician attention otherwise provided in an emergency department. Physicians typically spend [] minutes face-to-face with the patient and/or family.

Handwritten: A new code 99350

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

82 year old female established patient who is bedbound with advanced dementia. In the past few weeks she has developed 3 stage IV pressure ulcers on her hips and shoulder with purulent discharge from under an eschar. She is eating poorly and has had a Foley catheter placed by home health nurses since the pressure ulcers developed. The issue of gastrostomy feeding has not been resolved by the family, and there are differences of opinion among the caregivers. [family practice and home care]

12 year old male established wheelchair-bound patient high level spinal cord injured (C1-C2) tracheostomy and ventilator dependent in acute respiratory distress with high fever. Secretions have increased and difficult to manage. Parents have increased suctioning, bronchopulmonary toilet, and frequency of aerosol treatments. Prefer home management but concerned that child will go into acute respiratory failure and request physician evaluation. [pediatrics]

Description of Pre-Service Work:

The pre-service period includes services that are not performed at the patient's home, including: communications with other professionals and the patient and/or family; obtaining and/or reviewing written records, telephone reports, and the results of diagnostic and other studies.

Description of Intra-Service Work:

The intra-service period includes the services provided while you are with the patient and/or family in the patient's home. This includes the time in which the physician completes the history and physical examination, including evaluation of the patient's functional status, the environment and the caregiver's understanding and ability to provide the needed care. Additional "bundled" services such as drawing blood are part of intra-service work. Counseling the patient and/or family and communicating with other professionals from the patient's home are also included.

Description of Post-Service Work:

The post-service period includes services that are not provided at the patient's home such as: arranging for further services and coordination of care, reviewing results of studies, and communicating further with the patient, family, and other professionals including written and telephone reports. Post-service work associated with the house call cannot be counted toward care plan oversight (G0064) if that code is to be billed.

SURVEY DATA:

Specialty: Home Care, Family Practice, and Pediatrics

Sample Size: 58/270 Response Rate (%): 21% Median RVW: 3.53

25th Percentile RVW: 2.61 75th Percentile RVW: 4.00 Low: 0.70 High: 7.00

Median Pre-Service Time: 15 minutes Median Intra-Service Time: 72.5 minutes

25th Percentile Intra-Svc Time: 52.5 75th Percentile Intra-Svc Time: 90 Low: 20 High: 120

Median Post-Service Time: 20 minutes

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99255	Initial inpatient consultation	3.65
2)	99245	Office Consultation	3.43
3)			
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
993X3	15	72.5	20	5	4	5
99245	10	80	15	4	4	4
99255	5	110	15	4	4	4

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? 99353

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1,040,000+ (based on median survey response and number of physicians in specialties)

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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Attendance at Delivery - Tab 21

CPT code 99436, *Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn*, is a new code which describes the services of a physician who is requested by an obstetrician to attend the delivery. Attendance is not required for most deliveries and is only used for high risk deliveries such as a Caesarian section or meconium staining. A survey of 50 physicians showed a median RVU of 2.05. After considering comparisons to other evaluation and management services provided to the newborn, the RUC concluded that the specialty recommended value was too high. Code 99222, *Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history@ a comprehensive examination@ and medical decision making of 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 (RVU=2.14)*, was viewed by the RUC as more difficult and intense than 99436. The RUC recommends that 99436 be valued similar to 99233, *Subsequent hospital 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 (work rvu=1.51)*. The RUC recommends that 99436 should be valued at 1.50 RVUs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Code 93360 is used to report the total duration of time spent by a physician on a given date on standby. Standby service of less than 30 minutes total duration on a given date is not reported separately.</p> <p>Second and subsequent periods of standby beyond the first 30 minutes may be reported only if a full 30 minutes of standby was provided for each unit of service reported.</p>				
99360	AH1	<p>Physician standby service requiring prolonged physician attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for newborn care, for monitoring EEG)</p> <p><u>(99360 may be reported in addition to 99431, 99440, as appropriate)</u></p> <p><u>(99360 may not be reported in addition to 99436)</u></p>	XXX	NA
•99436	AH2	<p>Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn</p> <p><u>(99436 may be reported in addition to 99431)</u></p> <p><u>(99436 may not be reported in addition to 99440)</u></p>	XXX	1.50

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

CPT Code: 9943X Tracking Number: AH2 Global Period: XXX Recommended RVW: 2.05

CPT Descriptor:

**Attendance at delivery (when requested by delivering physician)
and initial stabilization of newborn.**

(9943X may be reported in addition to 99431)

(9943X may not be reported in addition to 99440)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A physician is requested by the obstetrician to attend the delivery of the 37 week gestation infant whose 32 year old mother arrived at the hospital with spontaneous rupture of her membranes at home. The physician arrives at the hospital, changes into scrub clothes, scrubs, and enters the delivery room suite. The physician commences introductions with the family, obtains the maternal and fetal histories from the obstetrician, and reviews the mother's chart and labor record. Attention is then turned to the equipment for neonatal care. The radiant warmer is checked, wall oxygen turned on and connected to the self-inflating resuscitation bag, the laryngoscope light checked and an appropriate sized blade chosen, wall suction adjusted, an appropriate sized endotracheal tube chosen, and the availability of medications is verified. Additionally, the physician reviews the medical and technical duties of the newborn resuscitation team who are present. The physician then gowns and scrubs and prepares to receive the newborn from the obstetrician after delivery and cord cutting.

Shortly after admission, the mother demonstrates the onset of vaginal bleeding with painful contractions associated with intermittent fetal tachycardia interspersed with deep variable deceleration. The obstetrician decides on a cesarean section which is done under general anesthesia. The physician is present during the birth of the child and provides any necessary assistance required to maintain the health of the child during the birthing process. The neonate is handed to the physician blue with a weak cry and a large amount of oral/nasal secretion. Initial heart rate is 100. The child is dried, stimulated, and the nasopharynx and oropharynx suctioned and the blow by oxygen provided. A visual inspection of the child is provided and the child appears consistent with 37 weeks of gestation with no other apparent anomalies. The one minute Apgar score is 5 but increases to 8 by 5 minutes. Blow by oxygen is discontinued at 8 minutes. The lungs are still moist but breath sounds are present in all lobes. The child begins to cry vigorously and color remains pink. The child is then wrapped in a blanket and given to the parents to hold. The parental concerns regarding the health of the newborn are addressed and any questions relating to the continuing care of the infant are answered, the physician completes the delivery room attendance, resuscitation record as well as the Apgar form.

Description of Pre-Service Work:

The pre-service work involved includes changing into scrub clothes, hand scrub, review of maternal prenatal and labor history, review of studies of newborn well being, preparation of the radiant warmer, adjustment of wall suction, checking ambu bag, turning on wall oxygen, checking laryngoscope blade and light, and assuring the availability of medications.

Description of Intra-Service Work:

Intra-service work includes receiving the newborn from the delivery physician, placing the child under the overhead warmer, drying, stimulating, bulb suctioning of the nose and mouth, a visual inspection of the child, obtaining a heart rate and respiratory rate, providing blow by oxygen as necessary, and assigning 1 and 5 minute apgar scores.

Description of Post-Service Work:

Post service work includes discussion of the care of the child with the obstetrician or delivering physician and parents as well as the completion of the delivery room attendance form and the apgar scoring sheet.

SURVEY DATA:

Specialty: American Academy of Pediatrics (AAP) and American Academy of Family Physicians (AAFP)

Sample Size: n=309 Response Rate (%): (53) 17.15% Median RVW: 2.05

25th Percentile RVW: 1.60 75th Percentile RVW: 2.65 Low: 1.11 High: 4.50

Median Pre-Service Time: 15 min Median Intra-Service Time: 25 min

25th Percentile Intra-Svc Time: 20 min 75th Percentile Intra-Svc Time: 35 min Low: 10 min High: 60 min

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 15 min

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99222	Initial hospital care; moderate complexity	2.14
2)	99252	Initial inpatient consultation; expanded	1.32
3)	99254	Initial inpatient consultation; moderate complexity	2.64
4)	99440	Newborn resuscitation	2.93

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgment	Median Technical Skill & Physical Effort	Median Psychological Stress
9943X	15 min	25 min	15 min	Median = 4.00 Mean = 3.89	Median = 4.00 Mean = 3.92	Median = 4.00 Mean = 4.40
99222	10 min	40 min	15 min	Median = 3.00 Mean = 3.62	Median = 3.00 Mean = 2.92	Median = 3.00 Mean = 3.08
99252	10 min	25 min	10 min	Median = 3.00 Mean = 3.22	Median = 3.00 Mean = 3.00	Median = 3.00 Mean = 3.11
99254	15 min	27.50 min	12.50 min	Median = 4.00 Mean = 3.88	Median = 3.00 Mean = 3.25	Median = 4.00 Mean = 3.63
99440	12.50 min	25 min	18.75 min	Median = 4.00 Mean = 4.43	Median = 5.00 Mean = 4.57	Median = 5.00 Mean = 4.86

•A significant number of the survey respondents compared the new attendance at delivery (when requested by attending physician) and initial stabilization of newborn code (9943X) to CPT code 99222 for an initial hospital care service of moderate complexity. The survey respondents found 9943X to have similar pre and post service physician work times as CPT code 99222, but slightly less intra service time. However, the survey respondents found the complexity/intensity of 9943X to be relatively higher than for CPT code 99222. CPT code 99222 is used to describe an initial hospital care service involving comprehensive history, comprehensive examination, and a medical decision making of moderate complexity. Based upon the complexity/intensity data, it can be determined that the survey respondents believed that the new CPT code (9943X) involved much greater medical decision making and physician skill.

•A large number of survey respondents compared the new attendance at delivery (when requested by attending physician) and initial stabilization of newborn code (9943X) to CPT code 99440 for newborn resuscitation. The survey respondents indicated that 9943X and 99440 had similar amounts of pre, intra and post service time. However, the data suggests that the survey respondents believed that 9943X involved slightly less mental effort and judgment, technical skill and physical effort, and psychological stress.

•CPT codes 99252 for an initial inpatient consultation with straightforward decision making and 99254 for initial inpatient consultation of moderate complexity were also used for comparison by the survey respondents who found these services involved similar amounts of pre, intra and post service work compared to 9943X. However, the data suggests that the survey respondents viewed the initial inpatient consultations as involving significantly less mental effort and judgment, technical skill and physical effort, and psychological stress than the new CPT code (9943X) for attendance at delivery and initial stabilization of newborn.

ADDITIONAL RATIONALE

For example, if recommended Revues are based on an alternative method instead of the survey results.

Discussion of RUCHE Survey Vignette:

C-section deliveries use to be more common in the United States. The number of C-section deliveries have dropped considerably in recent years. The immediate risks to the newborn associated with a C-section delivery are significantly greater than for a vaginal delivery, though, in many instances, a vaginal delivery may take substantially more physician time and physical effort. Neonatologists, general pediatricians, and, in certain parts of the country, family physicians have been requested and are attending an increasing number of vaginal deliveries as specified by hospital and managed care guidelines.

Close to 90% of the survey respondents (who answered the question) indicated that the survey vignette represented the typical patient and service. Therefore, based upon the experience of the survey respondents, it can be suggested that the survey vignette represents the typical birth for which specialists who provide care to newborn are presently being requested to attend and provide initial stabilization.

FREQUENCY INFORMATION

How was this service previously reported? CPT 99360 or CPT 99440

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

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

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

This attendance at a delivery (when requested by delivering physician) and initial stabilization of newborn is an extremely common procedure. There are approximately 4 million live births each year in the United States and approximately 20% are considered high risk either to the mother, fetus or newborn. Also, C-section deliveries represent approximately 12% of all live births in the United States each year. Virtually all C-section births in the United States involve the attendance of a physician dedicated strictly to the care of the newborn. It is becoming more and more common for a specialist concerned with the care of the newborn to be in attendance at every high risk delivery as specified by hospital and managed care guidelines. The respondents of the survey indicated that they provide this service approximately 33 times a year. Taking into account the number of this nation's neonatologists, general pediatricians, and family physicians who provide this service, it is estimated, based upon the survey data, that this service is provided between 1 million and 800,000 times per year.

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Destruction of Lesions - Tab 22

CPT code 17004, *...15 or more lesions*, is a new code which replaces several multiple lesion destruction codes. A HCPCS Level II code, G0053, is currently being used to describe the service. G0053 was assigned 3.05 work RVUs by HCFA. The survey for 17004 showed a median RVU of 3.05, but with a median intra-service time of 12 minutes. The RUC was concerned that the relatively high RVUs combined with low intra-service time resulted in a high intra-service work per-unit time (IWPUT), a constructed measure of intensity. For this reason the RUC recommends a lower work RVU for 17004. The RUC took its recommended RVU for 17000, 0.55, and its recommended RVU for 17003, 0.15, and extrapolated the values out to 15 lesions. The result is a RUC recommendation for 17004 of 2.65 RVUs.

CPT code 11200, *Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions*, has been revised to include 17200, *Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions*, which has been deleted. The RUC's recommendation for the revised 11200 is 0.69 RVUs which is the current value of 11200. Code 11200 is used approximately 70% more frequently than 17200 and survey data show a median RVU of 0.70.

CPT code 11201, *...each additional ten lesions*, has been revised to include 17201, *...each additional ten lesions (RVU=0.38)*, which has been deleted. The RUC's recommendation for the revised 11201 is 0.35 RVUs. Survey data showed a median RVU of 0.35. The combination of a higher survey median and a higher value for 17201 persuaded the RUC that code 11201 was previously undervalued at 0.26. For these reasons the RUC recommends an increase in the work RVU of 11201 to 0.35.

CPT code 17000, *Destruction by any method, including laser, with or without surgical curettage, all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia; first lesion*, has been combined with 17100 which was deleted. Previously 17000 was for lesions of the face and 17100 was for lesions other than face. The RUC recommends that the new work relative value for 17000 should be 0.55 RVUs. This value is equal to 70% of the current value of 17000, 0.56 RVUs, as it was previously reported and 30% of the value of 17100, 0.53 RVUs. The percentages are based on the specialty societies estimation of the portion of the time the old codes were utilized. The value of 0.55 RVUs is also supported by survey data which showed a median RVU of 0.59 and HCFA assignment of 0.55 RVUs to G0051, the HCPCS Level II code crosswalked to 17000.

CPT code 17003 *second through 14 lesions, each (List separately in addition to code for first lesion)*, is a new code which replaces 17001, 17002, 17101, and 17102. 17003 is to be used as an add-on code to 17000 for work on each lesion up to 14. The codes which it replaces are currently valued at 0.19, 0.19, 0.11, and 0.11 respectively. The survey median for 17003 is 0.19 RVUs. Based on the survey and the value of the old codes, the RUC recommends a value of 0.15 RVUs. This value is also supported by the current HCFA value of 0.18 RVUs for G0052, the HCPCS Level II code crosswalked to 17003.

CPT code 17110, *Destruction by any method of flat warts, molluscum contagiosum, or milia, up to and including 14 lesions*, was revised from its old description and the number of lesions treated reduced from 15. The survey median RVU was 0.67. However, the RUC was not convinced that there was compelling evidence to increase the RVUs above those established in refinement. For this reason the RUC recommends that the work RVUs should be maintained at 0.55.

CPT code 17111, *...15 or more lesions*, is a new code. Previously under the old codes removal of lesions in excess of 15 would be coded as 17110 x 2 with the second 17110 cut in half by the multiple procedure rule. The RUC chose to apply this same logic to the valuation of 171X3. If 17110 is valued at the RUC recommended 0.55, 17111 should equal $0.55 + 1/2(0.55)$ or 0.82. The RUC's recommendation of 0.82 RVUs is less than the dermatology survey median of 1.50.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Removal of Skin Tags				
Removal by scissoring, or any sharp method <u>or electrosurgical destruction or combination of treatment modalities</u> or ligature strangulation including chemical or electrocauterization of wound, with or without local anesthesia.				
11200*	QQ1	<i>Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions</i>	010	0.69 (no change)
11201	QQ2	<i>each additional ten lesions</i> (For electrosurgical destruction, see 17200, 17201)	ZZZ	0.35

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

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Destruction Destruction means the ablation of benign, premalignant or malignant tissues by any method, with or without curettement, including local anesthesia, and not usually requiring closure. Any method includes electrocautery, electrodesiccation <u>electrosurgery</u> , cryosurgery, laser and chemical treatment. Lesions include condylomata, papillomata, molluscum contagiosum, herpetic lesions, flat -warts (<u>ie, common, plantar, flat</u>), milia or other benign premalignant (<u>eg, actinic keratoses</u>) or malignant lesions. (For site specific destruction, see 40820, 46900-46917, 46924, 54050-54065, 56501, 56515, 57061, 57065, 67850, 68135) (For paring or cutting of benign hyperkeratotic lesions (eg, corn or calluses), see 11055-11057) (For sharp removal <u>or electrosurgical destruction</u> of skin tags and fibrocutaneous lesions <u>tags</u> , see codes 11200, 11201) (For electrosurgical destruction of skin tags, see codes 17200, 17201) (For destruction of malignant skin lesions, see codes 17260-17286) (For cryotherapy of acne, use see code 17340) (For shaving of epidural or dermal lesions, see 11300-11313)				
Destruction, Benign or Premalignant Lesions				
17000	QQ3	Destruction by any method, including laser, with or without surgical curettement, all benign facial lesions or premalignant lesions (<u>eg, actinic keratoses</u>) in any location, other than skin tags or benign lesions other than cutaneous vascular proliferative lesions, including local anesthesia; one <u>first</u> lesion	010	0.55

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
17001	QQ4 .19	second and third lesions, each (17001 has been deleted. To report, see 17003, 17004)	ZZZ	NA
17002	QQ5 .19	over three lesions, each additional lesion (17002 has been deleted. To report, see 17003, 17004)	ZZZ	NA
•17003	QQ6	second through 14 lesions, each (List separately in addition to code for first lesion) (Use 17003 only in addition to code 17000)	ZZZ	0.15
•17004	QQ7	15 or more lesions	010	2.65
17010	QQ8 1.01	— complication lesion (s) (17010 has been deleted. To report, see specific anatomic site code)	010	NA
17100*	QQ9 .53	Destruction by any method, including laser, of benign skin lesions other than cutaneous vascular proliferative lesions on any area other than the face, including local anesthesia; one lesion	010	NA
17101	QQ10 .11	second lesion	ZZZ	NA
17104	QQ11 2.01	15 or more lesions	010	NA
17105	QQ12 0.76	complicated or extensive lesions (17100-17105 have been deleted. To report, see 17000, 17003, 17004)	010	NA
17106		<i>Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 lesions</i>	090	4.54 (no change)

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

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
17107		10.0 - 50.0 sq cm	090	9.06 (no change)
17108		over 50 sq cm	090	13.10 (no change)
17110*	QQ13	Destruction by any method of flat warts, or molluscum contagiosum; <u>or</u> milia, up to 15 <u>14</u> lesions	010	0.55 (no change)
•17111	QQ14	15 or more lesions (For <u>destruction</u> of common or plantar warts, see 17000, <u>17003</u> , <u>17004</u> or 17100 series) (Retreatment same as office visit)	010	0.82
17200* .59	QQ15	Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions	010	NA
17201 .38	QQ16	— each additional ten lesions (For excision of fibrocutaneous tags, see 11200, 11201) (17200, 17201 have been deleted. To report, see 11200, 11201)	ZZZ	NA
17250		Chemical cauterization of granulation tissue (proud flesh, sinus or fistula) (17250 is not to be used with removal or excision codes <u>for the same lesion</u>)	000	0.50 (no change)

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 11200 Tracking Number: QQ1 Global Period: 010 Recommended RVW: 0.69
CPT Descriptor: Removal of skin tags, multiple fibrocutaneous tags, any area;
up to and including 15 lesions

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66 year old female presents with complaints of growing skin lesions on her neck. They are irritated by her collar and sometimes catch in her necklace, causing bleeding on one occasion. She has a family history of similar lesions. On examination there are 12 lesions from 3 to 6 mm size on the anterior and sides of the neck, all typical for the diagnosis of skin tags. Removal is recommended because they are symptomatic, the procedure is described and informed consent obtained. After cleansing the area with alcohol, each tag is anesthetized with 1% xylocaine. The smaller neck lesions are removed with scissors excision and aluminum chloride solution is applied topically for hemostasis. The larger neck lesions are electrodesiccated at their base to facilitate hemostasis prior to scissors excision. Polysporin ointment is applied along with a band-aid for the larger neck surgical sites.

Description of Pre-Service Work:

- Pre-operative evaluation, including review of pertinent data in medical records
- Discussion of choice of treatment or service options
- Review medical risks, such as syncope, bleeding, pain, edema, infection, headache, delayed healing, scarring, pigmentation, recurrence, paresthesias
- Informed consent obtained
- Necessary instructions to patient and staff
- Procedural preparation - electrosurgical equipment, disposable supplies including cautery tips, masks, gloves, appropriate lighting and draping if necessary
- Preparation of non-disposable equipment - including scissors and forceps
- Communication with family members accompanying patient

Pre-service: add for cryosurgery

- Procedural preparation (transfer liquid nitrogen to application container - cup with cotton tipped application, cryo spray unit, or cryo probe)
- Obtain protective shields and perform clean preparation

Description of Intra-Service Work:

- Inspect and palpate lesion for size, location, functional risks, depth
- Administer local anesthesia
- Electrosurgical destruction of lesion/Scissor removal of lesion
- Control of bleeding with aluminum chloride

Description of Post-Service Work:

- Apply antibiotic ointment
- Apply dressing, when appropriate
- Instruct patient on wound care, functional risks, and follow-up
- Instruct staff to schedule one month follow-up post surgical visit
- Communication with patient and family on post-operative care and follow-up
- Completion of medical record charting, including dictation of operative report and communication to referring physicians, if appropriate

SURVEY DATA:

Specialty: American Academy of Dermatology (AAD), American Society for Dermatologic Surgery (ASDS) and Society for Investigative Dermatology (SID)

Sample Size: 100 Response Rate (%): 35% (#35) Median RVW: 0.70

25th Percentile RVW: 0.69 75th Percentile RVW: 0.80 Low: 0.50 High: 1.95

Median Pre-Service Time: 4 minutes Median Intra-Service Time: 7 minutes

25th Percentile Intra-Svc Time: 5 75th Percentile Intra-Svc Time: 10 Low: 2 High: 15

Median Post-Service Time: 2 Total Time Number of Visits

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
1)	11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	0.69	010
2)	17200	Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions	0.59	010
3)	11400	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter 0.5 cm or less	0.86	010
4)	11100	Biopsy of skin....single lesion	0.81	000

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT 11200 is A DESCRIPTOR change in that the 11200 and 17200 skin tag series have been combined.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
11200	4	10	2	2	2	2
17200	4	10	2	2	2	2

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

NOT APPLICABLE

FREQUENCY INFORMATION

How was this service previously reported? 11200 or 17200

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 300,000

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS

SUMMARY OF RECOMMENDATION

CPT Code: 11201 Tracking Number: QQ2 Global Period: ZZZ Recommended RVW: 0.35
 CPT Descriptor: Removal of skin tags, multiple fibrocuteaneous tags, any area; each additional ten lesions
Vignette Used in Survey: A 66 year old female presents with complaints of growing skin lesions on her neck and axillary areas. She has a family history of similar lesions. The tags on her neck are irritated by her collars and catch in her necklaces; and the tags in the axillae itch in warm weather and with exercise. On examination there are 12 pedunculated papules on the sides of the neck, 3-5mm; and 11 tags, 2-6mm, in the axillary areas; all typical for the diagnosis of skin tags. Because the tags are symptomatic, removal is recommended. The procedure is described and informed consent obtained. After cleansing the area with alcohol, each tag is anesthetized with 1% xylocaine. The bases of the tags are electrodesiccated and the larger tags are removed by scissors excision. Aluminum chloride is applied as needed topically for hemostasis. The larger sites are covered with polysporin ointment and band-aids.

CLINICAL DESCRIPTION OF SERVICE:

Description of Pre-Service Work: Mainly performed under CPT 11200

- Pre-operative evaluation, including review of pertinent data in medical records
- Discussion of choice of treatment or service options
- Review medical risks, such as syncope, bleeding, pain, edema, infection, headache, delayed healing, scarring, pigmentation, recurrence, paresthesias
- Informed consent obtained
- Necessary instructions to patient and staff
- Procedural preparation - electrosurgical equipment, disposable supplies including cautery tips, masks, gloves, appropriate lighting and draping if necessary
- Preparation of non-disposable equipment - including scissors and forceps
- Communication with family members accompanying patient

Pre-service: add for cryosurgery

- Procedural preparation (transfer liquid nitrogen to application container - cup with cotton tipped application, cryo spray unit, or cryo probe)
- Obtain protective shields and perform clean preparation

Description of Intra-Service Work:

- Inspect and palpate lesion for size, location, functional risks, depth
- Administer local anesthesia
- Electrosurgical destruction of lesion/Scissor removal of lesion
- Control of bleeding with aluminum chloride

Description of Post-Service Work:

- Apply antibiotic ointment
- Apply dressing, when appropriate
- Instruct patient on wound care, functional risks, and follow-up
- Instruct staff to schedule one month follow-up post surgical visit
- Communication with patient and family on post-operative care and follow-up
- Completion of medical record charting, including dictation of operative report and communication to referring physicians, if appropriate

SURVEY DATA:

Specialty: American Academy of Dermatology (AAD), American Society for Dermatologic Surgery (ASDS) and Society for Investigative Dermatology (SID)

Sample Size: 100 Response Rate (%): 35% (#35) Median RVW: 0.35

25th Percentile RVW: 0.30 75th Percentile RVW: 0.46 Low: 0.10 High: 0.80

Median Pre-Service Time: 1 minute Median Intra-Service Time: 5 minutes

25th Percentile Intra-Svc Time: 3 75th Percentile Intra-Svc Time: 7.75 Low: 1 High: 20

Median Post-Service Time:	<u>1.5</u>	<u>Total Time</u>	<u>Number of Visits</u>
Office:		<u>7</u>	<u>1</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
1)	11101	Biopsy of skin...each separate/additional lesion	0.41	ZZZ
2)	17201	Electrosurgical destruction of multiple fibrocutaneous tags; each additional ten lesions	0.38	ZZZ
3)	11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional ten lesions	0.26	ZZZ

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
11101	3.5	4.5	2	2.5	2.5	2
17201	0.5	5	1	2	2	2

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

NOT APPLICABLE

FREQUENCY INFORMATION

How was this service previously reported? 11201 and 17201

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 50,000

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 17000 Tracking Number: QQ3 Global Period: 010 Recommended RVW: 0.59
CPT Descriptor: Destruction by any method, including laser, with or without surgical curettement, all benign or premalignant lesions (eg, actinic keratoses), other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia; first lesion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72 year old Caucasian female presents with a scaly, 6x5mm, erythematous papule, adjacent to the lateral canthus, of 4 months duration. Inspection and palpation of the lesion is compatible with the diagnosis of a hypertrophic actinic keratosis. Medication and allergy history is reviewed. The risks and benefits of various treatment options discussed and informed consent given. Liquid nitrogen is obtained from the central dispenser and poured into a disposable transfer cup. A small cotton tip applicator is used to apply the liquid nitrogen directly to the skin using a droplet technique without application of pressure. The application of liquid nitrogen is timed (based on the thickness of the lesion) so that once the ice ball forms it has a thaw time of 20-30 seconds. The patient is instructed on wound care. A blister and crust forms which requires cleansing with hydrogen peroxide and application of antibiotic ointment for approximately 7-10 days.

Description of Pre-Service:

- Pre-operative evaluation, including review of pertinent data in medical records
- Discussion of choice of treatment or service options
- Review medical risks, such as syncope, bleeding, pain, edema, infection, headache, delayed healing, scarring, pigmentation, recurrence, paresthesias
- Informed consent
- Necessary instructions to patient and staff
- Procedural preparation - electrosurgical equipment, disposable supplies including electrocautery tips, masks, gloves, appropriate lighting and drape, if necessary
- Preparation of non-disposable equipment - including curette and scissors
- Communications with family members accompanying patient

Pre-service: add for cryosurgery

- Procedural preparation (transfer liquid nitrogen to application container - cup with cotton tipped application, cryo spray unit, or cryo probe)
- Obtain protective shields and perform clean preparation

Description of Intra-Service:

- Inspect and palpate lesion for size, location, functional risks, depth
- Administer local anesthetic
- Electrosurgical destruction of lesion
- Application of dermal curette to lesion, two or more times
- Control of bleeding with additional destruction to lesion base using electrocautery unit as needed

Description of Post-Service Work:

- Apply antibiotic ointment
- Apply dressing, when appropriate
- Instruct patient on wound care, functional risks, risk of recurrence, and follow-up
- Instruct staff to schedule follow-up post-surgical visit
- Communication with patient and family on post-operative care and follow-up
- Completion of medical record charting, including dictation of operative report and communication to referring physician, if appropriate.

SURVEY DATA

Specialty: American Academy of Dermatology (AAD), American Society for Dermatologic Surgery (ASDS) and Society for Investigative Dermatology (SID)

Sample Size: 100 Response Rate (%): 35% (#35) Median RVW: 0.59

25th Percentile RVW: 0.55 75th Percentile RVW: 0.60 Low: 0.50 High: 1.00

Median Pre-Service Time: 4 minutes Median Intra-Service Time: 3 minutes

25th Percentile Intra-Svc Time: 2 75th Percentile Intra-Svc Time: 5 Low: 1 High: 8

Median Post-Service Time:	<u>2</u>	<u>Total Time</u>	<u>Number of Visits</u>
Office:		<u>11</u>	<u>1</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
1)	G0051	Same Descriptor	0.55	010
2)	11305	Shaving of epidermal or dermal lesion, single lesion scalp, neck, hands, feet, genitalia; lesion diameter 0.5cm or less	0.67	000
3)	17100	Destruction by any method, including laser, of benign skin lesions other than cutaneous vascular proliferative lesions on any area other than the face, including local anesthesia; one lesion	0.53	010
4)	17340	Cryotherapy (CO2 slush, liquid N2) for acne	0.73	010

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
G0051	3	5	1.75	3	3	2.5
11305	3	3	2	3	3	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

This code is a descriptor change that bundles the 17000 and 17100 destruction code series.

FREQUENCY INFORMATION

How was this service previously reported? 17000 or 17100

How often do physicians in your specialty perform this service? X Commonly Sometimes Rarely

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

Is this service performed by many physicians across the United States? X Yes No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS

SUMMARY OF RECOMMENDATION

CPT Code: 1700x1 Tracking Number: QQ6 Global Period: ZZZ Recommended RVW: 0.19

CPT Descriptor: Destruction by any method, including laser, with or without surgical curettement, all benign or premalignant lesions (eg, actinic keratoses), other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia; second through 14 lesions, each

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72 year old Caucasian female presents with a scaly, 6x5mm, erythematous papule, adjacent to the lateral canthus, and three additional lesions, one each on the face, cheek and forehead, each being 5x7mm of 4 months duration. Inspection and palpation of the lesions is compatible with the diagnosis of a hypertrophic actinic keratosis. Medication and allergy history is reviewed. The risks and benefits of various treatment options discussed and informed consent given. Liquid nitrogen is obtained from the central dispenser and poured into a disposable transfer cup. A small cotton tip applicator is used to apply the liquid nitrogen directly to the skin using a droplet technique without application of pressure. The application of liquid nitrogen is timed (based on the thickness of the lesion) so that once the ice ball forms it has a thaw time of 20-30 seconds. The patient is instructed on wound care. Blisters and crust forms on each which requires cleansing with hydrogen peroxide and application of antibiotic ointment for approximately 7-10 days.

Description of Pre-Service Work:

- Pre-operative evaluation, including review of pertinent data in medical records
- Discussion of choice of treatment or service options
- Review medical risks, such as syncope, bleeding, pain, edema, infection, headache, delayed healing, scarring, pigmentation, recurrence, paresthesias
- Informed consent
- Necessary instructions to patient and staff
- Procedural preparation - electrosurgical equipment, disposable supplies including electrocautery tips, masks, gloves, appropriate lighting and drape, if necessary
- Preparation of non-disposable equipment - including curette and scissors
- Communications with family members accompanying patient

Pre-service: add for cryosurgery

- Procedural preparation (transfer liquid nitrogen to application container - cup with cotton tipped application, cryo spray unit, or cryo probe)
- Obtain protective shields and perform clean preparation

Description of Intra-Service Work:

- Inspect and palpate lesion for size, location, functional risks, depth
- Administer local anesthetic
- Electrosurgical destruction of lesion
- Application of dermal curette to lesion, two or more times
- Control of bleeding with additional destruction to lesion base using electrocautery unit as needed

Description of Post-Service Work:

- Apply antibiotic ointment
- Apply dressing, when appropriate
- Instruct patient on wound care, functional risks, risk of recurrence, and follow-up
- Instruct staff to schedule follow-up post-surgical visit
- Communication with patient and family on post-operative care and follow-up
- Completion of medical record charting, including dictation of operative report and communication to referring physician, if appropriate.

SURVEY DATA:

Specialty: American Academy of Dermatology (AAD), American Society for Dermatologic Surgery (ASDS) and Society for Investigative Dermatology (SID)

Sample Size: 100 Response Rate (%): 35% (#35) Median RVW: 0.19

25th Percentile RVW: 0.18 75th Percentile RVW: 0.25 Low: 0.10 High: 0.55

Median Pre-Service Time: 1 minute Median Intra-Service Time: 2 minutes

25th Percentile Intra-Svc Time: 1 75th Percentile Intra-Svc Time: 5 Low: 1 High: 20

Median Post-Service Time: 1 Total Time Number of Visits

Office: 5 1

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
1)	G0052	Same Descriptor	0.18	ZZZ
2)	17001	Destruction by any method...; second and third lesions each	0.19	ZZZ

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
G0052	0.5	3.5	0.5	3	3	2
17001	2	2	1	2	2	2

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

NOT APPLICABLE

FREQUENCY INFORMATION

How was this service previously reported? 17001, 17002, 17101, 17102

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

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

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 1700x2 Tracking Number: QQ7 Global Period: 010 Recommended RVW: 3.05

CPT Descriptor: Destruction by any method, including laser, with or without surgical curettement, all benign or premalignant lesions (eg, actinic keratoses), other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia; 15 or more lesions

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old Caucasian male presents with 9 painful plantar verruca on the right foot and 6 warts on the left hand. The patient has unsuccessfully tried over-the-counter medications. Exam reveals nodules over the metatarsal head area and periungual warts on the left hand that are painful on palpation and limits the ability to function. Treatment options are discussed and informed consent given. The patient is placed prone. A metacarpal nerve block was performed on the left hand and a field block performed on the right foot by injecting 1% lidocaine with epinephrine 1:200,000. The electrosurgical unit is grounded to the patient, and a disposable tip placed in the cautery pencil. In the cutting mode each lesion is circumscribed. In the coagulation mode, the superficial portion of the nodule is cauterized. The sites are cleansed and debrided. Each base is cauterized again. The wound is again cleansed, antibiotic ointment applied, followed by a dressing. The patient is given a prescription for pain medication as needed and instructions on wound care.

Description of Pre-Service Work:

- Pre-operative evaluation, including review of pertinent data in medical records
- Discussion of choice of treatment or service options
- Review medical risks, such as syncope, bleeding, pain, edema, infection, headache, delayed healing, scarring, pigmentation, recurrence, paresthesias
- Informed consent
- Necessary instructions to patient and staff
- Procedural preparation - electrosurgical equipment, disposable supplies including electrocautery tips, masks, gloves, appropriate lighting and drape, if necessary
- Preparation of non-disposable equipment - including curette and scissors
- Communications with family members accompanying patient

Pre-service: add for cryosurgery

- Procedural preparation (transfer liquid nitrogen to application container - cup with cotton tipped application, cryo spray unit, or cryo probe)
- Obtain protective shields and perform clean preparation

Description of Intra-Service Work:

- Inspect and palpate lesion for size, location, functional risks, depth
- Administer local anesthetic
- Electrosurgical destruction of lesion
- Application of dermal curette to lesion, two or more times
- Control of bleeding with additional destruction to lesion base using electrocautery unit as needed

Description of Post-Service Work:

- Apply antibiotic ointment
- Apply dressing, when appropriate
- Instruct patient on wound care, functional risks, risk of recurrence, and follow-up
- Instruct staff to schedule follow-up post-surgical visit
- Communication with patient and family on post-operative care and follow-up
- Completion of medical record charting, including dictation of operative report and communication to referring physician, if appropriate.

SURVEY DATA:

Specialty: American Academy of Dermatology (AAD), American Society for Dermatologic Surgery (ASDS) and Society for Investigative Dermatology (SID)

Sample Size: 100 Response Rate (%): 35% (#35) Median RVW: 3.05

25th Percentile RVW: 3.00 75th Percentile RVW: 3.10 Low: 0.25 High: 4.0

Median Pre-Service Time: 5 minutes Median Intra-Service Time: 12 minutes

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 20 Low: 2 High: 45

Median Post-Service Time: 5

Total Time Number of Visits

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
1)	G0053	Same Descriptor	3.05	010
2)	11643	Excision, malignant lesion, face ears, eyelids, nose lips; lesion diameter 2.1 to 3.0cm	3.45	010

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
G0053	5	10	3	2	2.5	2
11643	10.5	37.5	5	4	4	3.5

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

NOT APPLICABLE

FREQUENCY INFORMATION

How was this service previously reported? 17000, 17001, 17002, 17100, 17101, 17102, 17104

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

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

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 17110 Tracking Number: QQ13 Global Period: 010 Recommended RVW: 0.67

CPT Descriptor: Destruction by any method of flat warts or molluscum contagiosum, milia; up to 14 lesions

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 23 year old woman presents with multiple growths on her legs. The number of growths has increased. She has not had any previous treatment. On examination there are flat-topped, red-tan papules, 1-2mm, on her pre-tibial areas. There are 10 papules on her right leg and 4 on her left leg. The diagnosis of verruca plana (flat warts) is made. Because these are infectious and can be spread, treatment is recommended. Alternative treatments, risks, and expected results are discussed. The individual warts are anesthetized with lidocaine 1% solution and lightly electrodesiccated. A curette is used to gently remove the charred warts. Aluminum chloride is applied as needed for hemostasis. Home care instructions are discussed with the patient and follow-up visit is scheduled.

Description of Pre-Service Work:

- Pre-operative evaluation, including review of pertinent data in medical records
- Discussion of choice of treatment or service options
- Review medical risks, such as syncope, bleeding, pain, edema, infection, headache, delayed healing, scarring, pigmentation, recurrence, paresthesias
- Informed consent
- Necessary instructions to patient and staff
- Procedural preparation - electrosurgical equipment, disposable supplies including electrocautery tips, masks, gloves, appropriate lighting and drape, if necessary
- Preparation of non-disposable equipment - including curette and scissors
- Communications with family members accompanying patient

Pre-service: add for cryosurgery

- Procedural preparation (transfer liquid nitrogen to application container - cup with cotton tipped application, cryo spray unit, or cryo probe)
- Obtain protective shields and perform clean preparation

Description of Intra-Service Work:

- Inspect and palpate lesion for size, location, functional risks, depth
- Administer local anesthetic
- Electrosurgical destruction of lesion
- Application of dermal curette to lesion, two or more times
- Control of bleeding with additional destruction to lesion base using electrocautery unit as needed

Description of Post-Service Work:

- Apply antibiotic ointment
- Apply dressing, when appropriate
- Instruct patient on wound care, functional risks, risk of recurrence, and follow-up
- Instruct staff to schedule follow-up post-surgical visit
- Communication with patient and family on post-operative care and follow-up
- Completion of medical record charting, including dictation of operative report and communication to referring physician, if appropriate.

SURVEY DATA:

Specialty: American Academy of Dermatology (AAD), American Society for Dermatologic Surgery (ASDS) and Society for Investigative Dermatology (SID)

Sample Size: 100 Response Rate (%): 35% (#35) Median RVW: 0.67

25th Percentile RVW: 0.55 75th Percentile RVW: 0.95 Low: 0.20 High: 2.80

Median Pre-Service Time: 3 minutes Median Intra-Service Time: 7 minutes

25th Percentile Intra-Svc Time: 6 75th Percentile Intra-Svc Time: 10 Low: 1 High: 25

Median Post-Service Time:	<u>3</u>	Total Time	Number of Visits
Office:		<u>14</u>	<u>1</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
1)	11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	0.69	010
2)	11100	Biopsy of skin....single lesion	0.81	000

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
11200	3	7	3	2	2	2
11100	2	5	2	2	2	1

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

NOT APPLICABLE

FREQUENCY INFORMATION

How was this service previously reported? 17110

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 100,000

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 1711x3 Tracking Number: QQ14 Global Period: ZZZ Recommended RVW: 1.50

CPT Descriptor: Destruction by any method of flat warts or molluscum contagiosum, milia; 15 or more lesions
CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 23 year old woman presents with multiple growths on her legs. The number of growths has increased. She has not had any previous treatment. On examination there are flat-topped, red-tan papules, 1-2mm, on her pre-tibial areas. There are 14 papules on her right leg and 11 on her left leg. The diagnosis of verruca plana (flat warts) is made. Because these are infectious and can be spread, treatment is recommended. Alternative treatments, risks, and expected results are discussed. The individual warts are anesthetized with lidocaine 1% solution and lightly electrodesiccated. A curette is used to gently remove the charred warts. Aluminum chloride is applied as needed for hemostasis. Home care instructions are discussed with the patient and follow-up visit is scheduled.

Description of Pre-Service Work:

- Pre-operative evaluation, including review of pertinent data in medical records
- Discussion of choice of treatment or service options
- Review medical risks, such as syncope, bleeding, pain, edema, infection, headache, delayed healing, scarring, pigmentation, recurrence, paresthesias
- Informed consent
- Necessary instructions to patient and staff
- Procedural preparation - electrosurgical equipment, disposable supplies including electrocautery tips, masks, gloves, appropriate lighting and drape, if necessary
- Preparation of non-disposable equipment - including curette and scissors
- Communications with family members accompanying patient

Pre-service: add for cryosurgery

- Procedural preparation (transfer liquid nitrogen to application container - cup with cotton tipped application, cryo spray unit, or cryo probe)
- Obtain protective shields and perform clean preparation

Description of Intra-Service Work:

- Inspect and palpate lesion for size, location, functional risks, depth
- Administer local anesthetic
- Electrosurgical destruction of lesion
- Application of dermal curette to lesion, two or more times
- Control of bleeding with additional destruction to lesion base using electrocautery unit as needed

Description of Post-Service Work:

- Apply antibiotic ointment
- Apply dressing, when appropriate
- Instruct patient on wound care, functional risks, risk of recurrence, and follow-up
- Instruct staff to schedule follow-up post-surgical visit
- Communication with patient and family on post-operative care and follow-up
- Completion of medical record charting, including dictation of operative report and communication to referring physician, if appropriate.

SURVEY DATA:

Specialty: American Academy of Dermatology (AAD), American Society for Dermatologic Surgery (ASDS) and Society for Investigative Dermatology (SID)

Sample Size: 100 Response Rate (%): 35% (#35) Median RVW: 1.50

25th Percentile RVW: 0.70 75th Percentile RVW: 2.50 Low: 0.19 High: 3.50

Median Pre-Service Time: 3 minutes Median Intra-Service Time: 10 minutes

25th Percentile Intra-Svc Time: 6 75th Percentile Intra-Svc Time: 14 Low: 3.5 High: 40

Median Post-Service Time: 2 Total Time Number of Visits

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
1)	G0053	Destruction...15 or more	3.05	010
2)	11100	Skin biopsy...single lesion	0.81	000
3)	11643	Excision, malignant lesion...2.1 to 3.0 cm	3.45	010

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
G0053	5	10	3	3	3	3
11100	5	5	4	2	3	2

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

This code is not equivalent physician work to 1700x2 or G0053.

FREQUENCY INFORMATION

How was this service previously reported? 17110

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 40,000

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS

APRIL 1997

Application of Halo - Tab 23

During the five-year review of the RBRVS, it was noted that although the CPT manual contained a code for the application and removal of a halo in an adult (code 20661), no such code existed for the pediatric population. Due to the fact that there is a significantly more physician work involved in this procedure in the pediatric population, the specialty societies believed that the most appropriate course of action would be to develop a new code. The services described by CPT code 20664, *Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology, (eg, pediatric patients, drocephalus, osteogenesis imperfecta), requiring general anesthesia* involve pre-operative CT evaluation of the skull, multiple pin site placement, and the necessity of general anesthesia. In contrast, the adult halo application code 20661 (4.27 RVUs) does not include the pre-operative CT evaluation of the skull multiple pin site placement, and does not require general anesthesia.

This procedure is performed on non-traumatic patients with significant spinal and skeletal deformities. In children, halo application requires the use of alternate methods of anesthesia. The halo ring is applied under general anesthesia, the patient is then awakened from the general anesthesia, and to ensure proper positioning the halo pins are applied using local anesthesia at the pin sites. The actual procedure lasts approximately 330 minutes.

Physicians have termed the halo a "crown of thorns" for children. Parents are often very reluctant to consider the halo as a suitable means of treatment for their children, therefore, the physician must spend a lot of time counseling the parents. In addition, the risk of complications is much higher in the pediatric population vs. adults. These complications include: pin loosening and infection at the pin site, usually due to incorrect pin placement.

Based on a survey of over 150 orthopaedic surgeons, pediatricians, and neurosurgeons, the RUC recommended a work value 7.0 RVUs for CPT code 20664 which represents the 75th percentile of the survey data.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•20664	TT1	Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology, (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta), requiring general anesthesia	090	7.0

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

CPT Code: 2066X Tracking Number: TTI Global Period: 090 Recommended RVW: 7.00

CPT Descriptor:

**Application of halo, including removal, cranial, 6 or more pins placed,
for thin skull osteology, (eg, pediatric patients, hydrocephalus,
osteogenesis imperfecta), requiring general anesthesia**

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A five year old child presents with fixed rotary atlantoaxial subluxation. This has not reduced in preliminary halter traction, and she is to be placed in a halo for purposes of attempted reduction and immobilization with fusion if indicated (general anesthesia will be utilized). Her age is predictive of the skull osteology necessitating a preoperative CT scan for halo pin placement determination.

Description of Pre-Service Work:

Pre-service work that occurs within 24 hours of the procedures divided into five areas.

- Appropriate counseling of the patient and family in regards to the needs for the halo as well as the technique involved: Because of the psychological impact of placement of pins in the skull significant counseling and education is necessary both of the family and the patient. This represents two separate areas of counseling. The counseling process is repeated just prior to surgery with clarifications of questions that may have occurred. Counseling not only involves the technique of specifics of cranial halo placement but also a thorough discussion of the need for the halo as opposed to alternate methods of treatment.
- Pre-Anesthesia evaluation of the patient and preparation for anesthesia: Appropriate evaluation of the patient for anesthesia includes medical evaluation by the physician and writing of orders that are appropriate as well as consultation with the anesthesiologist concerning unusual aspects of the case and/or procedure.
- Appropriate cranial evaluation: Because the patient's age is predictive of a thin skull that may allow penetration of the halo pins, the physician has ordered a CT Scan of the patient's skull prior to surgery. In this specific vignette the CT Scan has most likely been ordered prior to 24 hours before surgery and is now available for review by the physician. Evaluation of the CT Scan as to specific areas of skull thinness that may preclude halo pin placement is made. Selection of alternate pin placements sites is often necessary. All potential pin placement sites are evaluated on the appropriate CT sections.

- Sizing and obtaining appropriate halo: Pre-operative sizing of the patient's skull to make sure that an appropriate halo ring is available is necessary. This involves measuring the skull, noting any abnormalities in shape and obtaining all potentially necessary sizes. In addition, appropriate halo pins are requested. Immediately prior to surgery the equipment is reviewed.
- Operating Room Preparation: As the patient is brought into the operating suite and the anesthesiologist prepares to anesthetize the patient the surgeon prepares the operating table for placement of the halo. This often involves the use of an extension board for careful placement of the skull to allow halo placement. After induction of anesthesia the patient's head is brought into the appropriate position off the superior aspect of the operating table and held carefully in position by the surgeon. The use of a support board underneath the skull does not preclude holding the skull in place by the physician. The appropriate halo ring is then applied to make sure that adequate clearance in all areas of the skull are present. The skull is then prepped by shaving the appropriate areas to allow halo pin placement. At least 6 halo pins are utilized often up to ten. After shaving the appropriate sites these sites are then thoroughly prepped while the surgeon holds the skull.

Description of Intra-Service Work:

With the patient appropriately under anesthesia and the skull appropriately prepped, the halo ring is placed around the skull in the appropriate position just above the ears and just superorbital ridge. The 6 to 10 halo pins are then placed through the halo in a sterile manner and opposing pins are sequentially tightened.

In this 5 yr. old example sequential tightening of the pins occurs until approximately 3 to 4 pounds of pressure is documented on the torque screwdrivers. Repeated evaluation of the placement of the position of the ring and skull clearance is made during tightening of the halo pins. Local anesthesia is then injected at each of the pin sites. In the presented vignette the patient is then replaced on the operating table and awakened from anesthesia while holding the head in place.

Description of Post-Service Work:

The patient is returned to the recovery area and in the described vignette is placed in cervical traction using the cranial halo. Appropriate operative note is dictated and post-operative orders are written. Care is made to make sure that the traction appropriate. X-rays of the cervical spine are taken to confirm the position of the neck in traction. The procedure is then reviewed with the family. Following recovery from anesthesia the patient is appropriately monitored in the post anesthesia area and ward making sure that the halo pins are tolerated. Instruction of the family in regards to cleansing of the halo pins is the responsibility of the physician often with the assistance of the nursing staff. 24 to 48 hrs. after surgery the halo pins are once again tightened usually in the presence of sedation. A second episode of tightening may occur as per the preference of the physician. Daily evaluation of the halo pins occurs while the patient is hospitalized. In the vignette described the patient would be in the hospital for several days of traction prior to a decision to place the patient in a halo vest for operative or non operative care. As the vest is placed, careful evaluation of the position of the cervical spine is made by the physician. The physician is in attendance during placement of the thoracic vest attached to the cranial halo. Placement x-rays are then made to make sure the cervical spine is held in the appropriate position. Daily evaluation of the pin sites by the physician occurs. The family is re-instructed in pin site care.

Following discharge from the hospital the patient is seen in one week for re-evaluation of the cranial halo pins as well as the underlying cervical problem. In this 5 yr. old patient, the patient is seen at least every 3 weeks for evaluation of the pin sites in addition to any other necessary medical care. Should any of the pins become infected the pin may be removed and if necessary placed in an alternate site in the cranial halo ring. Placement of the pin in alternate pin site would require general anesthesia.

Removal of the cranial halo may occur within a 90 day global period. The cranial halo is removed in the physician's office after appropriate counseling of the patient and family. Sedation of the patient may be necessary. After detaching the halo from the vest the halo pins are sequentially loosened and the halo removed. Each of the halo pin sites is appropriately surgically scrubbed and antibiotic ointment often applied. Counseling of the family and patient reoccurs in regards to the cosmetic significance of the pin sites. The patient is seen in several days to reevaluate the pin sites.

SURVEY DATA:

Specialty: American Academy of Pediatrics (AAP),
American Academy of Orthopaedic Surgeons (AAOS), and
American Association of Neurological Surgeons (AANS)

Sample Size: n=156 Response Rate (%): 17 % (26) Median RVW: 6.25

25th Percentile RVW: 5.50 75th Percentile RVW: 7.00 Low: 4.50 High: 10.00

Median Pre-Service Time: 90 minutes Median Intra-Service Time: 60 minutes

25th Percentile Intra-Svc Time: 45 min 75th Percentile Intra-Svc Time: 75 min Low: 45 min High: 120 min

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 30 min

ICU: 20 min 1

Other Hospital: 40 min 3

Office: 80 min 4

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	20661	Application of Halo, including removal; cranial	4.27
2)	25611	Percutaneous skeletal fixation of distal radial fracture	7.11
3)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
2066X	90 min	60 min	180 min	median = 4.00 mean = 4.00	median = 3.50 mean = 3.46	median = 4.00 mean = 3.85
20661	60 min	45 min	125 min	median = 3.00 mean = 3.11	median = 3.00 mean = 2.84	median = 3.00 mean = 2.89
25611	60 min	60 min	115 min	median = 3.00 mean = 2.83	median = 2.50 mean = 2.67	median = 2.00 mean = 2.17

•The survey respondents indicated significantly more pre, intra, and post service time for the new CPT code 2066X than for the reference CPT code 20661 (adult halo). A significant number of survey respondents used CPT code 20661 as a reference.

•The survey respondents second most common reference was CPT code 25611. The data from the survey respondents indicates that the new CPT code 2066X was presented as having significantly more pre and post service time than CPT code 25611.

•Complexity/intensity information from the survey results indicates that 2066X was viewed as having dramatically higher mental effort and judgement, technical skill and physician effort, and psychological stress than both reference services.

•The IWPUP values for 2066X are considerably lower than both reference codes (see table below)

CPT Code	IWPUP
2066X	.020 (using recommended RVU of 7.00)
20661	.023*
25611	.049

Note: AAP/AAOS/AANS representatives believe that reference service CPT code 20661 has an historically low intensity IWPUP compared to other procedures of this nature.

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

•To provide some additional insight into the valuation of CPT code 2066X, an Evaluation and Management (E/M) building block method was applied to the survey respondent data. Please see the table below for the results of the building block method of valuation which suggests a RVU of 12.09 for CPT code 2066X. Based upon the building block method, the recommended RVU of 7.00 appears to justified.

Component of Service	Survey Time (median)	Related CPT Code	Multiplied by	1997 RVU	RVU for Each Component of the Service
PRE	90 minutes	99214	1	1.10	1.10
INTRA	60 minutes	XXXX	(.06) IWPUT	3.60 (60 min * .06 IWPUT)	3.60
POST	30 minutes	99231	1	0.64	0.64
ICU	20 minutes	99233	1	1.51	1.51
OTHER HOSP DISCHARGE	40 minutes	99231	2	0.64	1.28
		99238	1	1.28	1.28
OFFICE	80 minutes	99213	4	0.67	2.68
TOTAL RVU					12.09

FREQUENCY INFORMATION

How was this service previously reported? CPT 20661

How often do physicians in your specialty perform this service? Commonly ☒ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 200

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Arthroscopy of the Ankle - Tab 24

New CPT codes were added to describe ankle arthroscopy. CPT code 29891, *Arthroscopy, ankle, surgical; excision of osteochondral defect of talus and tibia, including drilling of the defect* involves visualization of the joint, minor synovial resection, injection and/or joint aspiration, soft tissue or invasive distraction, and abrasion arthroplasty of the defect. The typical patient presents with symptoms of ankle pain and swelling with past traumatic injury. CPT code 29892, *Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)* involves visualization of the joint, minor synovial resection, injection or aspiration of the joint, incidental articular shaving, removal of loose bodies, soft tissue or invasive distraction and internal fixation.

The specialty society reported that CPT code 29891 is similar in terms of pre-and post-operative work to reference code 29898, *Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive* (8.03 RVUs) although the condition that are being treated are different. Based on a survey of 51 orthopaedic surgeons, the RUC recommended an RVU of 8.60 for this procedure which represents the survey median.

CPT code 29892 is a combination of procedures as noted above and similar in nature to reference code 29898, the work involved in 29892 is more complex. The intra-service time for 29892 is 90 minutes vs. 60 minutes of intra-operative time for 29898. Based on a survey of 51 orthopaedic surgeons, the RUC recommended an RVU of 8.00 for this procedure which represents the survey median.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•29891	VV1	Arthroscopy, ankle, surgical; excision of osteochondral defect of talus and of tibia, including drilling of the defect	090	8.00
•29892	VV2	Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)	090	8.60

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 298X1 (VV1)

Global Period: 090

Recommended RVW: 8.00

CPT Descriptor: Arthroscopy, ankle, surgical; excision of osteochondral defect of talus and of tibia, including drilling of the defect

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male with a history of severe ankle sprain has a several month history of pain, snapping, and swelling of the ankle associated with an osteochondral defect demonstrated on imaging studies. He undergoes arthroscopic debridement of the defect, including drilling of the defect.

Description of Pre-Service Work: An interval history and physical examination are performed. The findings of the examination and diagnostic studies are reviewed with the patient and family. A complete review of the available imaging diagnostic studies, including possibly MRI or CT scan, occurs within 24 hours prior to surgery to carefully plan the portals of entry for the procedure. These studies are obtained to make certain that they are present for reference in the operating room. Options of treatment and recommendations are reviewed with the patient and family and operative consent obtained. Review with the operating room staff to plan for the availability of necessary instrumentation occurs prior to surgery. Upon entering the operating room, the presence and proper functioning of the equipment is checked. Under appropriate anesthesia, the patient is positioned using ankle distraction, either skeletal or with a skin traction device. A tourniquet is applied on the lower extremity and supervision of appropriate surgical prepping and draping of the patient follows. The lower extremity is exsanguinated and the tourniquet inflated to appropriate pressures.

Description of Intra-Service Work: A portal is made into the ankle joint. This portal is usually in the anterior medial aspect of the ankle and occurs by placing a large bore needle near the ankle joint so that appropriate saline or other solution can be instilled to allow for distraction of the ankle. Scalpel blade is utilized to divide the skin for placement of the operating portal as well as the arthroscopy portal. After the ankle is distended, an initial portal is made, usually anterior lateral for placement of the arthroscope. A separate anterior medial portal is then made for operating tools. Distraction of the ankle occurs with either manual traction by an assistant or the placement of a calcaneal pin. Then careful systematic evaluation of the ankle ensues. This is predicated on appropriate flow of saline or other solution through the ankle to allow visualization of all surfaces. A probe is inserted through the operating portal and any loose bodies or defects are carefully evaluated. In this procedure, an osteochondral defect has been demonstrated on the imaging studies and is verified. Osteochondral defect is then curetted through the operating portal until all loose portions are removed. A clean peripheral cut of the lesion is noted. The ankle is thoroughly irrigated and then the tailored defect is serially drilled through the operating portal. Serial visualization and multiple positions of the entire occurs throughout the entire procedure. Following the completion of drilling all loose material is removed from the ankle joint with the flow of saline. The operating instruments and arthroscope are removed. Sutures are placed at each of the portal sites.

Description of Post-Service Work: includes monitoring patient stabilization; communicating with the family and other health care professionals (including written and oral reports and orders); and antibiotic and pain medication management. Instruction as to non-weight bearing crutch ambulation occurs. The patient is discharged to home on appropriate medications. The day after the procedure, the patient is examined and range of motion exercises initiated. Follow-up in the office then occurs during the first week after surgery at which time the wounds are examined, the lower extremity is evaluated, and range of motion exercises once again instructed. Postoperative x-rays are obtained and reviewed at this office visit. Additional office visits through the 90-day global period are necessary to monitor range of motion and physiotherapy progress. Repeat X-rays are obtained and reviewed six to eight weeks postoperatively.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons

Survey n:	281	RVW	PRE	INTRA	POST (details)							
Response:	51				SD	ICU		Hosp. - Other		DD	Office	
Rate %:	18%		total	total	total	#	total	#	total	total	#	total
			min	min	min	visits	min	visits	min	min	visits	min
	low	6.40		30								
	25th%	7.13		50								
	MED	8.00	50	60	25	0	0	0	0	10	4	60
	75th%	8.43		90								
	high	13.50		120								

Comparative Data for Surveyed Service and Key Reference Service(s):

CPT	Resp n	RVW	PRE (min)	INTRA (min)	HOSP Post (min)	OFF Post (min)	ME & J* mean	TS & PE* mean	PS* mean
VV1	51	8.00	50	60	35	60	3.37	3.92	3.20
29898	27	8.03	60	60	45	60	3.33	3.67	2.96
29887	32	8.58	60	85	45	60	3.56	4.00	3.44

*ME & J: mental effort and judgment. TS & PE: technical skill and physical effort. PS: psychological stress.

KEY REFERENCE SERVICE(S):

<u>1997 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
8.03	090	29898	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive
8.58	090	29887	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Although the intracicular pathology of VV1 is different than 29898, the surgical technique and the preoperative work and postoperative care is very similar. The RVW for VV1 is lower than the reference service 29887 when comparing intraservice time and the placement of internal fixation when performing 29887. An RVW of 8.00 is recommended.

ADDITIONAL RATIONALE (eg, if recommended RVUs are based on an alternative method instead of the survey results):

Using the E&M building block approach and *conservatively* using 0.06 rvu's for the intraoperative IWPOT (the range for the reference service IWPOTs was 0.059-0.078), the total RVW for VV1 would be approximately 8.66. This calculation supports the recommended RVW of 8.00 for VV1.

<u>Component</u>	<u>Time</u>	<u>CPT</u>	<u>RVW</u>		<u>RVW</u>
Pre-service	50 min	99214	1.10	=	1.10
Intra-service	60 min		@0.06	=	3.60
Same day	35 min	99238	1.28	=	1.28
Office visits	60 min	4x99213	0.67	=	<u>2.68</u>
Total RVWs using building block methodology					8.66

FREQUENCY INFORMATION

How was this service previously reported?

29897 Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, limited

29898 Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive

How often do physicians in your specialty perform this service?

Sometimes

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

25,000-30,000

Is this service performed by many physicians across the United States?

Yes

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 298X2 (VV2)

Global Period: 090

Recommended RVW: 8.60

CPT Descriptor: Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 25-year-old female has injury to ankle with marked swelling and large osteochondral fracture demonstrated on imaging studies. She undergoes arthroscopic reduction and internal fixation of the fracture.

Description of Pre-Service Work: An interval history and physical examination are performed. The findings of the examination and diagnostic studies are reviewed with the patient and family. A complete review of the available imaging diagnostic studies, including possibly MRI or CT scan, occurs within 24 hours prior to surgery to carefully plan the portals of entry for the procedure. These studies are obtained to make certain that they are present for reference in the operating room. Options of treatment and recommendations are reviewed with the patient and family and operative consent obtained. Review with the operating room staff to plan for the availability of necessary instrumentation occurs prior to surgery. Upon entering the operating room, the presence and proper functioning of the equipment is checked. Under appropriate anesthesia, the patient is positioned using ankle distraction, either skeletal or with a skin traction device. A tourniquet is applied on the lower extremity and supervision of appropriate surgical prepping and draping of the patient follows. The lower extremity is exsanguinated and the tourniquet inflated to appropriate pressures.

Description of Intra-Service Work: A portal is made into the ankle joint. This portal is usually in the anterior medial aspect of the ankle and occurs by placing a large bore needle near the ankle joint so that appropriate saline or other solution can be instilled to allow for distraction of the ankle. Scalpel blade is utilized to divide the skin for placement of the operating portal as well as the arthroscopy portal. After the ankle is distended, an initial portal is made, usually anterior lateral for placement of the arthroscope. A separate anterior medial portal is then made for operating tools. Distraction of the ankle occurs with either manual traction by an assistant or the placement of a calcaneal pin. Then careful systematic evaluation of the ankle ensues. This is predicated on appropriate flow of saline or other solution through the ankle to allow visualization of all surfaces. A probe is inserted through the operating portal and any loose bodies or defects are carefully evaluated. In this procedure, a large osteochondral defect or talar dome fracture has been demonstrated on the imaging studies and is verified surgically. Under direct arthroscopic visualization, a guide is inserted using both arthroscopic and fluoroscopic control to internally fix the osteochondral fracture. This fixation may include screw fixation, K-wire fixation, or use of biologically absorbable fixation devices. Following adequate fixation, verified both arthroscopically and fluoroscopically, the ankle is thoroughly irrigated. The operating instruments and arthroscope are removed. Sutures are placed at the surgical incisions, and a splint is applied.

Description of Post-Service Work: includes monitoring patient stabilization; communicating with the family and other health care professionals (including written and oral reports and orders); and antibiotic and pain medication management. The day after the procedure, the patient is examined and range of motion exercises initiated. Instruction as to non-weight bearing crutch ambulation occurs. The patient is discharged to home on appropriate medications. Follow-up in the office occurs during the first week after surgery at which time the wounds are examined, the lower extremity is evaluated, and range of motion exercises once again instructed. Postoperative x-rays are obtained and reviewed at this office visit. Additional office visits through the 90-day global period are necessary to monitor range of motion and physiotherapy progress. Repeat x-rays are obtained and reviewed six to eight weeks postoperatively. Weight bearing is allowed when X-rays demonstrate healing.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons

Survey n:	281	RVW	PRE	INTRA	POST (details)							
Response:	48				SD	ICU		Hosp. - Other		DD	Office	
Rate %:	17%		total	total	total	#	total	#	total	total	#	total
			min	min	min	visits	min	visits	min	min	visits	min
	low	6.95		45								
	25th%	8.44		75								
	MED	8.60	60	90	30	0	0	0	0	10	4	60
	75th%	9.80		120								
	high	19.50		180								

Comparative Data for Surveyed Service and Key Reference Service(s):

CPT	Resp n	RVW	PRE (min)	INTRA (min)	HOSP Post (min)	OFF Post (min)	ME & J* mean	TS & PE* mean	PS* mean
VV2	51	8.60	60	90	40	60	3.96	4.42	3.77
29887	32	8.58	60	85	45	60	3.56	4.00	3.44
29898	27	8.03	60	60	45	60	3.33	3.67	2.96

*ME & J: mental effort and judgment. TS & PE: technical skill and physical effort. PS: psychological stress.

KEY REFERENCE SERVICE(S):

1997 RVW	Global	CPT	Descriptor
8.58	090	29887	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation
8.03	090	29898	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

VV2 is a more complex procedure in terms of the pathology dealt with and the technical skills required for fracture treatment than 29898 (Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement extensive) as demonstrated by the difference in intraoperative time of 90 minutes versus 60 minutes. The intraoperative time of VV2 compares well with 29887 (Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation). The intensity for VV2 is higher than 29887. The survey median of 8.60 is recommended.

ADDITIONAL RATIONALE (eg, if recommended RVUs are based on an alternative method instead of the survey results):

Using the E&M building block approach and *conservatively* using 0.06 rvu's for the intraoperative IWPOT (the range for the reference service IWPOTs was 0.059-0.074), the total RVW for VV2 would be approximately 10.46. This calculation supports the recommended RVW of 8.60 for VV2.

<u>Component</u>	<u>Time</u>	<u>CPT</u>	<u>RVW</u>		<u>RVW</u>
Pre-service	60 min	99214	1.10	=	1.10
Intra-service	90 min		@0.06	=	5.40
Same day	40 min	99238	1.28	=	1.28
Office visits	60 min	4x99213	0.67	=	<u>2.68</u>
Total RVWs using building block methodology					10.46

FREQUENCY INFORMATION

How was this service previously reported?

28445 Open treatment of talus fracture, with or without internal or external fixation

How often do physicians in your specialty perform this service?

Sometimes

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

5,000-10,000

Is this service performed by many physicians across the United States?

Yes

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Arthroscopy of the Hip - Tab 25

A new family of hip arthroscopy codes were added to CPT. Unlike the other arthroscopic procedures, these procedures are performed rarely, and the specialty society reported that they expect that these codes will rarely be reported. The specialty noted that unlike the other major joints including; the shoulders, knees, elbows, and ankles, the hip is a much deeper joint and is a more difficult area to work in because the surgeon must avoid soft tissue and critical nerves and blood vessels. In addition, unlike other arthroscopic procedure, hip arthroscopy is performed under x-ray which increases the amount of physician work that is involved.

Based on a survey 29 orthopaedic surgeons, the RUC recommended 7.75 RVUs for code 29860, *Arthroscopy, hip diagnostic with or without synovial biopsy (separate procedure)*, 9.00 RVUs for code 29861, *Arthroscopy, hip, surgical; with removal of loose body or foreign body*, 9.50 RVUs for code 29862, *Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum]*, and 9.50 RVUs for code 29863, *Arthroscopy, hip, surgical; with synovectomy*. The recommendations for 29860 and 29861 represent the survey median and the recommendations for 29862 and 29863 represent the 25th percentile of the survey results.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•29860	WW1	Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)	090	7.75
•29861	WW2	Arthroscopy, hip, surgical; with removal of loose body or foreign body	090	9.00
•29862	WW3	with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum	090	9.50
•29863	WW4	with synovectomy	090	9.50

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 298X1 (WW1)

Global Period: 090

Recommended RVW: 7.75

CPT Descriptor: Arthroscopy, hip, diagnostic, with or without synovial biopsy (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 17-year-old female sustains a twisting injury to her left hip playing tennis. She presents with acute pain, limitation of motion, and inability to bear weight. All diagnostic imaging studies are negative, but there continues to be painful restriction of motion despite non-operative management. A hip arthroscopy is performed revealing an entrapped acetabular labrum which spontaneously reduces.

Description of Pre-Service Work: An interval history and physical examination are performed. The findings of the examination and diagnostic studies are reviewed with the patient and family. Options of treatment and recommendations are then reviewed. Planning of the procedure is coordinated with the family, operating room staff, and rehabilitation team. All arthroscopic and video equipment to be used during the case is inspected for proper function. The presence and proper functioning of special arthroscopic instruments unique to hip arthroscopy are checked. Under general or epidural anesthesia, the patient is positioned supine on a fracture table for distraction of the operative hip. Careful attention to detail in positioning is important for protecting the perineum from pressure problems and assuring adequate ability to distract the hip intraoperatively. The ability to distract the hip is confirmed by fluoroscopic examination with a C-arm. The amount of force required for traction is carefully monitored. Traction is then released until ready to begin arthroscopy. The operative hip area is then sterilely prepared and draped in a standard fashion. The C-arm is positioned between the legs to provide an AP fluoroscopic view of the hip. Traction is then reapplied.

Description of Intra-Service Work: Three standard arthroscopic portals are placed for assessment of the hip: anterior, anterolateral, and posterolateral. The anterolateral portal is positioned first because it lies most centrally in the safe zone for arthroscopy. Pre-positioning is performed with a spinal needle placed into the joint under fluoroscopic control. The joint is then distended with fluid to further facilitate distraction. Traction is carefully monitored intraoperatively, maintaining the minimal amount of traction force necessary to maintain distraction. After pre-positioning with the spinal needle, the arthroscopic cannula is placed in the anterolateral position for initial introduction of the arthroscope. Subsequent positioning of the anterior and posterolateral portals is then facilitated by direct intraarticular visualization from the arthroscope as well as fluoroscopic guidance by the C-arm. The anterior portal is established next. The direction of this portal is approximately 45° cephalad and 30° toward the midline. Pre-positioning is again performed with a spinal needle and the cannula subsequently placed into the joint. The cannula is passed into the joint in a controlled fashion under arthroscopic visualization to avoid scuffing of the articular surfaces. The posterolateral portal is then established in an identical fashion, pre-positioning with the spinal needle under fluoroscopic control. Once all three portals have been established, systematic arthroscopic examination of the hip is carried out. The entire articular surface of the acetabulum, the acetabular labrum, acetabular fossa including the ligamentum teres, and most of the articular surface of the femoral head are inspected and assessed. The assessment reveals a hypermobile entrapped acetabular labrum which is reduced to its normal position outside the joint. The articular surfaces, ligamentum teres and synovium appear healthy. Upon completion of the procedure, the instrumentation is removed and the traction immediately released. The portals are reapproximated with single 5-0 nylon sutures. A bulky dressing is applied.

Description of Post-Service Work: The patient is observed closely in the outpatient setting for four hours. The patient is then discharged home, protected weight bearing on crutches, with detailed instructions on follow-up care and appropriated medication orders. Physician follow-up care is one week postoperatively, at which time sutures are removed and further details of the operative findings are discussed. Initial progress in rehabilitation is assessed and further plans for supervised physical therapy and home exercises are reviewed. Additional office follow-up visits occur within the 90-day global period for periodic examination of the operative hip and review and adjustment of the recovery program.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons

Survey n:	161	RVW	PRE	INTRA	POST (details)								
Response:	29		total min	total min	SD total min	ICU		Hosp. - Other		DD total min	Office		
Rate %:	18%					# visits	total min	# visits	total min		# visits	total min	
	low				5.70		30						
	25th%	7.00		45									
	MED	7.75	75	70	30	0	0	0	0	10	3	45	
	75th%	9.00		90									
	high	13.00		150									

Comparative Data for Surveyed Service and Key Reference Service(s):

CPT	Resp n	RVW	PRE (min)	INTRA (min)	HOSP Post (min)	OFF Post (min)	ME & J* mean	TS & PE* mean	PS* mean	LOS
WW1	29	7.75 <i>med</i>	75	70	40	45	3.79	4.10	3.83	0
WW2	29	9.00 <i>med</i>	75	80	40	45	3.90	4.31	3.79	0
WW3	29	9.50 25th%	75	100	45	60	4.21	4.52	3.86	0
WW4	29	9.50 25th%	75	100	45	60	4.03	4.55	3.90	0
29815	10	5.74	60	43	45	45	3.50	3.60	2.70	0
29819	25	7.33	60	60	40	45	3.16	3.64	3.04	0
29821	8	7.43	60	75	45	68	3.75	4.00	3.63	0
29823	21	7.86	60	60	50	60	3.38	3.48	3.00	0

*ME & J: mental effort and judgment. TS & PE: technical skill and physical effort. PS: psychological stress.

KEY REFERENCE SERVICE(S):

1997 RVW	Global	CPT	Descriptor
5.74	090	29815	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

WW1 *Arthroscopy, hip, diagnostic, with or without synovial biopsy (separate procedure)* is compared to the analogous shoulder arthroscopy code 29815 *Arthroscopy, shoulder, diagnostic, with or without synovial biopsy*. WW1 requires a more involved room setup and patient positioning with a fracture table and the use of x-ray for positioning of operative cannulae. The traction required introduces risk of traction neuropraxia to a greater degree than the arm support devices used with shoulder arthroscopy. Although both codes WW1 and 29815 are both diagnostic codes with or without a synovectomy, the placement of the arthroscope within the hip joint (WW1) and subsequent placement of portals with the introduction of operative cannulae is much more technically demanding and time consuming than in the shoulder (29815). WW1 requires three portals while 29815 requires two. In 29815, the arthroscope can be moved about within the joint to allow for adequate visualization in contradiction to WW1. In order to adequately visualize the entire articular surface of femoral head and acetabulum while performing WW1,

arthroscopes of varying degrees of field of vision must be shifted from one portal to another as well as changing the position of the hip while on the fracture table. Postoperative time and work in terms of monitoring extremity support (crutches for WW1 and sling for 29815) and regaining range of motion are similar with both codes. The survey median RVW of 7.75 is recommended.

ADDITIONAL RATIONALE (eg, if recommended RVUs are based on an alternative method instead of the survey results):

1. The relativity of the RVWs for the family 29815-29823 compare well with the family WW1-WW4 if the median survey RVW is used for WW1 and WW2 and the 25th percentile survey RVW is used for WW3 and WW4, as shown below,

5.74	29815	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)
7.33	29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
7.86	29823	Arthroscopy, shoulder, surgical; debridement, extensive
7.43	29821	Arthroscopy, shoulder, surgical; synovectomy, complete
7.75	WW1	Arthroscopy, hip, diagnostic, with or without synovial biopsy (separate procedure)
9.00	WW2	Arthroscopy, hip, surgical; with removal of loose body or foreign body
9.50	WW3	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum
9.50	WW4	Arthroscopy, hip, surgical; with synovectomy

2. Using the E&M building block approach, and *conservatively* using 0.06 rvu's for the intraoperative IWPUT (the range for the reference service IWPUTs was 0.06-0.08), the total RVW for WW1 would be approximately 8.59. This calculation supports the recommended RVW of 7.75 for WW1.

<u>Component</u>	<u>Time</u>	<u>CPT</u>	<u>RVW</u>		<u>RVW</u>
Pre-service	75 min	99214	1.10	=	1.10
Intra-service	70 min		@0.06	=	4.20
Same day	40 min	99238	1.28	=	1.28
Office visits	45 min	3x99213	0.67	=	<u>2.01</u>
Total RVWs using building block methodology					8.59

FREQUENCY INFORMATION

How was this service previously reported?

29909 Unlisted procedure, arthroscopy

How often do physicians in your specialty perform this service? Rarely

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

For new Codes 298X1(WW1)-298X4(WW4): The incidence of hip disease amenable to arthroscopy is increasing as the ability to diagnose these types of lesions improves. There are approximately 250 admissions per year for hip arthroscopy in select arthroscopy centers. It is estimated that approximately an equal number of cases are performed outside of these centers for a total of 500 admissions per year.

Is this service performed by many physicians across the United States? No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 298X2 (WW2)

Global Period: 090

Recommended RVW: 9.00

CPT Descriptor: Arthroscopy, hip, surgical; with removal of loose body or foreign body

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 16-year-old male presents with painful catching in his right hip two years following closed treatment of a right acetabular fracture. Computerized tomography reveals multiple intraarticular bony loose bodies. After assessing the clinical presentation, arthroscopy is performed with removal of the symptomatic loose bodies.

Description of Pre-Service Work: An interval history and physical examination are performed. The findings of the examination and diagnostic studies are reviewed with the patient and family. Options of treatment and recommendations are then reviewed. Planning of the procedure is coordinated with the family, operating room staff, and rehabilitation team. All arthroscopic and video equipment to be used during the case is inspected for proper function. The presence and proper functioning of special arthroscopic instruments unique to hip arthroscopy are checked. Under anesthesia, with adequate muscle relaxation, the patient is positioned supine on a fracture table for distraction of the operative hip. The ability to distract the hip is confirmed by fluoroscopic examination with a C-arm. The amount of force required is noted via a tensiometer in the foot plate, used for applying traction. Traction is then released until ready to begin arthroscopy. The operative hip area is then sterilely prepared and draped in a standard fashion. The C-arm is positioned between the legs to provide an AP fluoroscopic view of the hip. Traction is then reapplied.

Description of Intra-Service Work: Three standard arthroscopic portals are placed for assessment of the hip: anterior, anterolateral, and posterolateral. The anterolateral portal is positioned first because it lies most centrally in the safe zone for arthroscopy. Pre-positioning is performed with a spinal needle placed into the joint under fluoroscopic control. The joint is then distended with fluid to further facilitate distraction. Traction is carefully monitored intraoperatively, maintaining the minimal amount of traction force necessary to maintain distraction. After pre-positioning with the spinal needle, the arthroscopic cannula is placed in the anterolateral position for initial introduction of the arthroscope. Subsequent positioning of the anterior and posterolateral portals is then facilitated by direct intraarticular visualization from the arthroscope as well as fluoroscopic guidance by the C-arm. The anterior portal is established next. The direction of this portal is approximately 45° cephalad and 30° toward the midline. Pre-positioning is again performed with a spinal needle and the cannula subsequently placed into the joint. The cannula is passed into the joint in a controlled fashion under arthroscopic visualization to avoid scuffing of the articular surfaces. The posterolateral portal is then established in an identical fashion, pre-positioning with the spinal needle under fluoroscopic control. Once all three portals have been established, arthroscopic examination of the hip is carried out, which allows identification of the number, location, and size of intraarticular loose bodies. Retrieval requires that the loose bodies be visualized from one portal while they are instrumented from another. Maneuvering loose bodies into position is performed with various intraoperative manipulations of the hip combined with variations of suction and inflow. Smaller loose bodies are debrided through motorized shave blades. Intermediate sized loose bodies are removed through large cannulas. Larger loose bodies require removal with hand instruments as these cannot be placed through the cannula. Once the portal tracts have been developed, hand instruments can be navigated through the tract into the joint. Enlarging the capsular and skin incision may be necessary for removing the fragments intact. Upon completion of the procedure, the instrumentation is removed and the traction immediately released. The portals are reapproximated and a bulky dressing is applied.

Description of Post-Service Work: The patient is observed closely in the outpatient setting for four hours. The patient is then discharged home, protected weight bearing on crutches, with detailed instructions on follow-up care and appropriated medication orders. Physician follow-up care is one week postoperatively, at which time sutures are removed and further details of the operative findings are discussed. Initial progress in rehabilitation is assessed and further plans for supervised physical therapy and home exercises are reviewed. Additional office follow-up visits occur within the 90-day global period for periodic examination of the operative hip and review and adjustment of the recovery program.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons

Survey n:	161	RVW	PRE	INTRA	POST (details)							
Response:	29				SD	ICU		Hosp. - Other		DD	Office	
Rate %:	18%		total	total	total	#	total	#	total	total	#	total
			min	min	min	visits	min	visits	min	min	visits	min
	low	7.46		30								
	25th%	8.20		60								
	MED	9.00	75	80	30	0	0	0	0	10	3	45
	75th%	12.00		115								
	high	15.00		180								

Comparative Data for Surveyed Service and Key Reference Service(s):

CPT	Resp n	RVW	PRE (min)	INTRA (min)	HOSP Post (min)	OFF Post (min)	ME & J* mean	TS & PE* mean	PS* mean	LOS
WW1	29	7.75 <i>med</i>	75	70	40	45	3.79	4.10	3.83	0
WW2	29	9.00 <i>med</i>	75	80	40	45	3.90	4.31	3.79	0
WW3	29	9.50 <i>25th%</i>	75	100	45	60	4.21	4.52	3.86	0
WW4	29	9.50 <i>25th%</i>	75	100	45	60	4.03	4.55	3.90	0
29815	10	5.74	60	43	45	45	3.50	3.60	2.70	0
29819	25	7.33	60	60	40	45	3.16	3.64	3.04	0
29821	8	7.43	60	75	45	68	3.75	4.00	3.63	0
29823	21	7.86	60	60	50	60	3.38	3.48	3.00	0

*ME & J: mental effort and judgment. TS & PE: technical skill and physical effort. PS: psychological stress.

KEY REFERENCE SERVICE(S):

1997 RVW	Global	CPT	Descriptor
7.33	090	29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

WW2 *Arthroscopy, hip, surgical; with removal of loose body or foreign body* is compared with the analogous shoulder arthroscopy code 29819 *Arthroscopy, shoulder, surgical; with removal of loose body or foreign body*. WW2 requires a more involved room setup and patient positioning with a fracture table and the use of x-ray for positioning of operative cannulae. The traction required introduces risk of traction neuropraxia to a greater degree than the arm support devices used with shoulder arthroscopy. Although both codes WW2 and 29819 are both codes involving the adequate inspection of the joint and loose body removal, the placement of the arthroscope within the hip joint (WW2) and subsequent placement of portals with the introduction of operative cannulae is much more technically demanding and time consuming than in the shoulder (29819). WW2 requires three portals while 29819 requires two. In 29819, the arthroscope can be moved about within the joint to allow for adequate visualization in contradiction to WW2. In order to adequately visualize the entire articular surface of femoral head and acetabulum while performing WW2, the arthroscopes of varying degrees of field of vision must be shifted from one portal to another as

well as changing the position of the hip while on the fracture table. The introduction of grasping instruments through operative cannulae is similar with both codes but technically more difficult with WW2 because of the inability to move instruments around within the joint and the subsequent need for changing arthroscope and operative portals in order to gain the best "line of sight" and direct approach with operative instruments. Postoperative time and work in terms of monitoring extremity support (crutches for WW2 and sling for 29819) and regaining range of motion are similar with both codes. The survey median RVW of 9.00 is recommended.

ADDITIONAL RATIONALE (eg, if recommended RVUs are based on an alternative method instead of the survey results):

1. The relativity of the RVWs for the family 29815-29823 compare well with the family WW1-WW4 if the median survey RVW is used for WW1 and WW2 and the 25th percentile survey RVW is used for WW3 and WW4, as shown below,

5.74	29815	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)
7.33	29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
7.86	29823	Arthroscopy, shoulder, surgical; debridement, extensive
7.43	29821	Arthroscopy, shoulder, surgical; synovectomy, complete
7.75	WW1	Arthroscopy, hip, diagnostic, with or without synovial biopsy (separate procedure)
9.00	WW2	Arthroscopy, hip, surgical; with removal of loose body or foreign body
9.50	WW3	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum
9.50	WW4	Arthroscopy, hip, surgical; with synovectomy

2. Using the E&M building block approach and *conservatively* using 0.06 rvu's for the intraoperative IWPUP (the range for the reference service IWPUPs was 0.06-0.08), the total RVW for WW2 would be approximately 9.19 This calculation supports the recommended RVW of 9.00 for WW2.

<u>Component</u>	<u>Time</u>	<u>CPT</u>	<u>RVW</u>		<u>RVW</u>
Pre-service	75 min	99214	1.10	=	1.10
Intra-service	80 min		@0.06	=	4.80
Same day	40 min	99238	1.28	=	1.28
Office visits	45 min	3x99213	0.67	=	<u>2.01</u>
Total RVWs using building block methodology					9.19

FREQUENCY INFORMATION

How was this service previously reported? 29909 Unlisted procedure, arthroscopy

How often do physicians in your specialty perform this service? Rarely

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

For new Codes 298X1(WW1)-298X4(WW4): The incidence of hip disease amenable to arthroscopy is increasing as the ability to diagnose these types of lesions improves. There are approximately 250 admissions per year for hip arthroscopy in select arthroscopy centers. It is estimated that approximately an equal number of cases are performed outside of these centers for a total of 500 admissions per year.

Is this service performed by many physicians across the United States? No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 298X3 (WW3)

Global Period: 090

Recommended RVW: 9.50

CPT Descriptor: Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47-year-old female presents with a nine month history of unexplained insidious onset of right hip pain. Imaging studies reveal a joint effusion and diagnostic work-up fails to suggest a cause. Hip arthroscopy reveals a Grade IV chondral lesion in the acetabulum and the presence of a chronically inverted labrum. Chondroplasty, abrasion arthroplasty, and resection of the labrum is performed.

Description of Pre-Service Work: An interval history and physical examination are performed. The findings of the examination and diagnostic studies are reviewed with the patient and family. Options of treatment and recommendations are then reviewed. Planning of the procedure is coordinated with the family, operating room staff, and rehabilitation team. All arthroscopic and video equipment to be used during the case is inspected for proper function. The presence and proper functioning of special arthroscopic instruments unique to hip arthroscopy are checked. Under anesthesia, with adequate muscle relaxation, the patient is positioned supine on a fracture table for distraction of the operative hip. The ability to distract the hip is confirmed by fluoroscopic examination with a C-arm. The amount of force required is noted via a tensiometer in the foot plate, used for applying traction. Traction is then released until ready to begin arthroscopy. The operative hip area is then sterilely prepared and draped in a standard fashion. The C-arm is positioned between the legs to provide an AP fluoroscopic view of the hip. Traction is then reapplied.

Description of Intra-Service Work: Three standard arthroscopic portals are placed for assessment of the hip: anterior, anterolateral, and posterolateral. The anterolateral portal is positioned first because it lies most centrally in the safe zone for arthroscopy. Pre-positioning is performed with a spinal needle placed into the joint under fluoroscopic control. The joint is then distended with fluid to further facilitate distraction. Traction is carefully monitored intraoperatively, maintaining the minimal amount of traction force necessary to maintain distraction. After pre-positioning with the spinal needle, the arthroscopic cannula is placed in the anterolateral position for initial introduction of the arthroscope. Subsequent positioning of the anterior and posterolateral portals is then facilitated by direct intraarticular visualization from the arthroscope as well as fluoroscopic guidance by the C-arm. The anterior portal is established next. The direction of this portal is approximately 45° cephalad and 30° toward the midline. Pre-positioning is again performed with a spinal needle and the cannula subsequently placed into the joint. The cannula is passed into the joint in a controlled fashion under arthroscopic visualization to avoid scuffing of the articular surfaces. The posterolateral portal is then established in an identical fashion, pre-positioning with the spinal needle under fluoroscopic control. Once all three portals have been established, arthroscopic examination of the hip is carried out, which reveals a 6 x 14 mm Grade IV chondral defect in the superolateral aspect of the acetabulum. Remnants of fragmented articular surface are debrided. The surrounding margins of articular cartilage appear healthy. Vascular channels are created in the depths of the crater by perforating holes through the subchondral plate with arthroscopic awls. Also noted is a chronically inverted acetabular labrum as an explanation for the secondary development of the articular surface damage. Selective resection of the unstable portion is performed, debriding back to healthy, stable labrum. Upon completion of the procedure, the instrumentation is removed and the traction immediately released. The portals are reapproximated and a bulky dressing is applied.

Description of Post-Service Work: The patient is observed closely in the outpatient setting for four hours. The patient is then discharged home, protected weight bearing on crutches, with detailed instructions on follow-up care and appropriated medication orders. Physician follow-up care is one week postoperatively, at which time sutures are removed and further details of the operative findings are discussed. Initial progress in rehabilitation is assessed and further plans for supervised physical therapy and home exercises are reviewed. Additional office follow-up visits occur within the 90-day global period for periodic examination of the operative hip and review and adjustment of the recovery program.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons

Survey n:	161	RVW	PRE	INTRA	POST (details)							
Response:	29				SD	ICU		Hosp. - Other		DD	Office	
Rate %:	18%		total min	total min	total min	# visits	total min	# visits	total min	total min	# visits	total min
	low	7.86		30								
	25th%	9.50		75								
	MED	11.00	75	100	30	0	0	0	0	15	4	60
	75th%	12.00		120								
	high	16.50		180								

Comparative Data for Surveyed Service and Key Reference Service(s):

CPT	Resp n	RVW	PRE (min)	INTRA (min)	HOSP Post (min)	OFF Post (min)	ME & J* mean	TS & PE* mean	PS* mean	LOS
WW1	29	7.75 med	75	70	40	45	3.79	4.10	3.83	0
WW2	29	9.00 med	75	80	40	45	3.90	4.31	3.79	0
WW3	29	9.50 25th %	75	100	45	60	4.21	4.52	3.86	0
WW4	29	9.50 25th%	75	100	45	60	4.03	4.55	3.90	0
29815	10	5.74	60	43	45	45	3.50	3.60	2.70	0
29819	25	7.33	60	60	40	45	3.16	3.64	3.04	0
29821	8	7.43	60	75	45	68	3.75	4.00	3.63	0
29823	21	7.86	60	60	50	60	3.38	3.48	3.00	0
27033	19	12.38	60	90	65	60	3.47	3.58	3.53	2

*ME & J: mental effort and judgment. TS & PE: technical skill and physical effort. PS: psychological stress.

KEY REFERENCE SERVICE(S):

1997 RVW	Global	CPT	Descriptor
7.86	090	29823	Arthroscopy, shoulder, surgical; debridement, extensive
12.38	090	27033	Arthrotomy, hip, with exploration or removal of loose or foreign body

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

WW3 Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum is compared with the analogous shoulder arthroscopy code 29823 Arthroscopy, shoulder, surgical; debridement, extensive. WW3 requires a more involved room setup and patient positioning with a fracture table and the use of x-ray for positioning of operative cannulae. The traction required introduces risk of traction neuropraxia to a greater degree than the arm support devices used with shoulder arthroscopy. Although both codes WW3 and 29823 require adequate inspection of the joint and excision of damaged tissue, the placement of the arthroscope within the hip joint (WW3) and subsequent placement of portals with the

introduction of operative cannulae is much more technically demanding and time consuming than in the shoulder (29823). WW3 requires three portals while 29823 requires two. In 29823, the arthroscope can be moved about within the joint to allow for adequate visualization in contradiction to WW3. In order to adequately visualize the entire articular surface of femoral head and acetabulum while performing WW3, the arthroscopes of varying degrees of field of vision must be shifted from one portal to another as well as changing the position of the hip while on the fracture table. The introduction of hand held and motorized instruments through operative cannulae is similar with both codes but technically more difficult with WW3 because of the inability to move instruments around within the joint and the subsequent need for changing arthroscope and operative portals in order to gain the best "line of sight" and direct approach with operative instruments. Intraoperative hemostasis with cautery or laser is required in both WW3 and 29823. Post operative time and work in terms of monitoring extremity support (crutches for WW3 and sling for 29823) and regaining range of motion is similar with both codes.

Reference service 27033 *Arthrotomy, hip, with exploration or removal of loose or foreign body* is an open procedure requiring a hospital stay and a longer time on crutches for joint protection and a longer time for wound healing. The surgical approach adds the risk of potential avascular necrosis of the femoral head should extensive intraoperative manipulation of the hip be required. Therefore, WW3 is less work than 27033.

The orthopaedic committee reviewing the surveys for WW1-WW4 agree that the relationship of RVWs between these codes should be similar to the relationship between the shoulder codes (29815-29823). Therefore, the survey 25th percentile RVW of 9.50 is recommended for WW3.

ADDITIONAL RATIONALE (eg, if recommended RVUs are based on an alternative method instead of the survey results):

1. The relativity of the RVWs for the family 29815-29823 compare well with the family WW1-WW4 if the median survey RVW is used for WW1 and WW2 and the 25th percentile survey RVW is used for WW3 and WW4, as shown below,

5.74	29815	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)
7.33	29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
7.86	29823	Arthroscopy, shoulder, surgical; debridement, extensive
7.43	29821	Arthroscopy, shoulder, surgical; synovectomy, complete
7.75	WW1	Arthroscopy, hip, diagnostic, with or without synovial biopsy (separate procedure)
9.00	WW2	Arthroscopy, hip, surgical; with removal of loose body or foreign body
9.50	WW3	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum
9.50	WW4	Arthroscopy, hip, surgical; with synovectomy

2. Using the E&M building block approach and *conservatively* using 0.06 rvu's for the intraoperative IWP/UT (the range for the reference service IWP/UTs was 0.06-0.08), the total RVW for WW3 would be approximately 11.06. Although this supports the survey median RVW, the orthopaedic committee recommends the 25th percentile RVW of 9.50 for WW3 to maintain family relationship.

<u>Component</u>	<u>Time</u>	<u>CPT</u>	<u>RVW</u>		<u>RVW</u>
Pre-service	75 min	99214	1.10	=	1.10
Intra-service	100 min		@0.06	=	6.00
Same day	45 min	99238	1.28	=	1.28
Office visits	60 min	4x99213	0.67	=	<u>2.68</u>
Total RVWs using building block methodology					11.06

FREQUENCY INFORMATION

How was this service previously reported?

29909 Unlisted procedure, arthroscopy

How often do physicians in your specialty perform this service?

Rarely

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

For new Codes 298X1(WW1)-298X4(WW4): The incidence of hip disease amenable to arthroscopy is increasing as the ability to diagnose these types of lesions improves. There are approximately 250 admissions per year for hip arthroscopy in select arthroscopy centers. It is estimated that approximately an equal number of cases are performed outside of these centers for a total of 500 admissions per year.

Is this service performed by many physicians across the United States?

No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 298X4 (WW4)

Global Period: 090

Recommended RVW: 9.50

CPT Descriptor: Arthroscopy, hip, surgical; with synovectomy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 34-year-old male with rheumatoid disease presents with a three month history of severe right hip pain. Symptoms persist despite appropriate treatment for underlying disease, intra-articular steroid injection, and protected weight bearing. Hip arthroscopy with an extensive synovectomy is performed.

Description of Pre-Service Work: Pre-Service Work: An interval history and physical examination are performed. The findings of the examination and diagnostic studies are reviewed with the patient and family. Options of treatment and recommendations are then reviewed. Specifically, the eventual merits of a total hip arthroplasty are highlighted. However, because of his relatively young age and recent onset of symptoms, uncontrollable with conservative measures, arthroscopy is offered as a palliative and temporizing alternative. Planning of the procedure is coordinated with the family, operating room staff, and rehabilitation team. All arthroscopic and video equipment to be used during the case is inspected for proper function. The presence and proper functioning of special arthroscopic instruments unique to hip arthroscopy are checked. Under anesthesia, with adequate muscle relaxation, the patient is positioned supine on a fracture table for distraction of the operative hip. The ability to distract the hip is confirmed by fluoroscopic examination with a C-arm. The amount of force required is noted via a tensiometer in the foot plate, used for applying traction. Traction is then released until ready to begin arthroscopy. The operative hip area is then sterilely prepared and draped in a standard fashion. The C-arm is positioned between the legs to provide an AP fluoroscopic view of the hip. Traction is then reapplied.

Description of Intra-Service Work: Three standard arthroscopic portals are placed for assessment of the hip: anterior, anterolateral, and posterolateral. The anterolateral portal is positioned first because it lies most centrally in the safe zone for arthroscopy. Pre-positioning is performed with a spinal needle placed into the joint under fluoroscopic control. The joint is then distended with fluid to further facilitate distraction. Traction is carefully monitored intraoperatively, maintaining the minimal amount of traction force necessary to maintain distraction. After pre-positioning with the spinal needle, the arthroscopic cannula is placed in the anterolateral position for initial introduction of the arthroscope. Subsequent positioning of the anterior and posterolateral portals is then facilitated by direct intraarticular visualization from the arthroscope as well as fluoroscopic guidance by the C-arm. The anterior portal is established next. The direction of this portal is approximately 45° cephalad and 30° toward the midline. Pre-positioning is again performed with a spinal needle and the cannula subsequently placed into the joint. The cannula is passed into the joint in a controlled fashion under arthroscopic visualization to avoid scuffing of the articular surfaces. The posterolateral portal is then established in an identical fashion, pre-positioning with the spinal needle under fluoroscopic control. Once all three portals have been established, arthroscopic examination of the hip is carried out, which reveals proliferative synovial disease as well as advance articular surface damage with subchondral cyst formation. Extensive resection is carried out. Upon completion of the procedure, the instrumentation is removed and the traction immediately released. The portals are reapproximated and a bulky dressing is applied.

Description of Post-Service Work: The patient is observed closely in the outpatient setting for four hours. The patient is then discharged home, protected weight bearing on crutches, with detailed instructions on follow-up care and appropriated medication orders. Physician follow-up care is one week postoperatively, at which time sutures are removed and further details of the operative findings are discussed. Initial progress in rehabilitation is assessed and further plans for supervised physical therapy and home exercises are reviewed. Additional office follow-up visits occur within the 90-day global period for periodic examination of the operative hip and review and adjustment of the recovery program.

SURVEY DATA: Specialty(s): American Academy of Orthopaedic Surgeons

Survey n:	161	RVW	PRE	INTRA	POST (details)							
Response:	29		total min	total min	SD total min	ICU		Hosp. - Other		DD total min	Office	
Rate %:	18%					# visits	total min	# visits	total min		# visits	total min
	low	7.43		45								
	25th%	9.50		80								
	MED	11.50	75	100	30	0	0	0	0	15	4	60
	75th%	13.00		120								
	high	15.70		180								

Comparative Data for Surveyed Service and Key Reference Service(s):

CPT	Resp n	RVW	PRE (min)	INTRA (min)	HOSP Post (min)	OFF Post (min)	ME & J* mean	TS & PE* mean	PS* mean	LOS
WW1	29	7.75 <i>med</i>	75	70	40	45	3.79	4.10	3.83	0
WW2	29	9.00 <i>med</i>	75	80	40	45	3.90	4.31	3.79	0
WW3	29	9.50 <i>25th%</i>	75	100	45	60	4.21	4.52	3.86	0
WW4	29	9.50 <i>25th%</i>	75	100	45	60	4.03	4.55	3.90	0
29815	10	5.74	60	43	45	45	3.50	3.60	2.70	0
29819	25	7.33	60	60	40	45	3.16	3.64	3.04	0
29821	8	7.43	60	75	45	68	3.75	4.00	3.63	0
29823	21	7.86	60	60	50	60	3.38	3.48	3.00	0
27033	19	12.38	60	90	65	60	3.47	3.58	3.53	2

*ME & J: mental effort and judgment. TS & PE: technical skill and physical effort. PS: psychological stress.

KEY REFERENCE SERVICE(S):

1997 RVW	Global	CPT	Descriptor
7.43	090	29821	Arthroscopy, shoulder, surgical; synovectomy, complete
12.38	090	27033	Arthrotomy, hip, with exploration or removal of loose or foreign body

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S): Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

WW4 *Arthroscopy, hip, surgical; with synovectomy* is compared with the analagous shoulder arthroscopy code 29821 *Arthroscopy, shoulder, surgical; synovectomy, complete*. WW4 requires a more involved room setup and patient positioning with a fracture table and the use of x-ray for positioning of operative cannulae. The traction required introduces risk of traction neuropraxia to a greater degree than the arm support devices used with shoulder arthroscopy. Although both codes WW4 and 29821 require adequate inspection of the joint and excision of damaged tissue, the placement of the arthroscope within the hip joint (WW4) and subsequent placement of portals with the introduction of operative cannulae is much more technically demanding and time consuming than in the shoulder (29821). WW4 requires three portals while 29821 requires two. In 29821, the arthroscope can be moved about within

the joint to allow for adequate visualization in contradiction to WW4. In order to adequately visualize the entire articular surface of femoral head and acetabulum while performing WW4, the arthroscopes of varying degrees of field of vision must be shifted from one portal to another as well as changing the position of the hip while on the fracture table. The introduction of hand held and motorized instruments through operative cannulae is similar with both codes but technically more difficult with WW4 because of the inability to move instruments around within the joint and the subsequent need for changing arthroscope and operative portals in order to gain the best "line of sight" and direct approach with operative instruments. Intraoperative hemostasis with cautery or laser is required in both WW4 and 29821. Post operative time and work in terms of monitoring extremity support (crutches for WW4 and sling for 29821) and regaining range of motion is similar with both codes.

Reference service 27033 *Arthrotomy, hip, with exploration or removal of loose or foreign body* is an open procedure requiring a hospital stay and a longer time on crutches for joint protection and a longer time for wound healing. The surgical approach adds the risk of potential avascular necrosis of the femoral head should extensive intraoperative manipulation of the hip be required. Therefore, WW4 is less work than 27033.

The orthopaedic committee reviewing the surveys for WW1-WW4 agree that the relationship of RVWs between these codes should be similar to the relationship between the shoulder codes (29815-29823). Therefore, the survey 25th percentile RVW of 9.50 is recommended for WW4.

ADDITIONAL RATIONALE (eg, if recommended RVUs are based on an alternative method instead of the survey results):

1. The relativity of the RVWs for the family 29815-29823 compare well with the family WW1-WW4 if the median survey RVW is used for WW1 and WW2 and the 25th percentile survey RVW is used for WW3 and WW4, as shown below,

5.74	29815	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)
7.33	29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
7.86	29823	Arthroscopy, shoulder, surgical; debridement, extensive
7.43	29821	Arthroscopy, shoulder, surgical; synovectomy, complete
7.75	WW1	Arthroscopy, hip, diagnostic, with or without synovial biopsy (separate procedure)
9.00	WW2	Arthroscopy, hip, surgical; with removal of loose body or foreign body
9.50	WW3	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum
9.50	WW4	Arthroscopy, hip, surgical; with synovectomy

2. Using the E&M building block approach and *conservatively* using 0.06 rvu's for the intraoperative IWPUT (the range for the reference service IWPUTs was 0.06-0.08), the total RVW for WW4 would be approximately 11.06. Although this supports the survey median RVW, the orthopaedic committee recommends the 25th percentile RVW of 9.50 for WW4 to maintain family relationship.

<u>Component</u>	<u>Time</u>	<u>CPT</u>	<u>RVW</u>		<u>RVW</u>
Pre-service	75 min	99214	1.10	=	1.10
Intra-service	100 min		@0.06	=	6.00
Same day	45 min	99238	1.28	=	1.28
Office visits	60 min	4x99213	0.67	=	<u>2.68</u>
Total RVWs using building block methodology					11.06

FREQUENCY INFORMATION

How was this service previously reported?

29909 Unlisted procedure, arthroscopy

How often do physicians in your specialty perform this service?

Rarely

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

For new Codes 298X1(WW1)-298X4(WW4): The incidence of hip disease amenable to arthroscopy is increasing as the ability to diagnose these types of lesions improves. There are approximately 250 admissions per year for hip arthroscopy in select arthroscopy centers. It is estimated that approximately an equal number of cases are performed outside of these centers for a total of 500 admissions per year.

Is this service performed by many physicians across the United States?

No

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
FEBRUARY AND APRIL 1997

Transurethral Destruction of Prostate Tissue - Tab 23 and Tab 26

A new code 53850 was added to describe the work involved in transurethral microwave thermotherapy. This procedure is used primarily for the treatment of benign prostatic hyperplasia (BPH). The procedure provides minimally invasive, non-surgical partial destruction of prostatic tissue by combining microwave heating and conductive cooling. Since TUMT is a relatively new treatment many patients that present with symptomatic BPH undergo transurethral resection of the prostate which is described by CPT codes 52601, 52612, and 52614. TUMT requires no anesthesia and has a minimal period of convalescence. Since patients are awake during the procedure, the physician is required to provide constant assurance to the patient. The work involved in TUMT is more difficult than lithotripsy which is described by code 50590. The RUC recommended an RVU of 9.58 for this service which is based on the survey median from over 30 urologists.

CPT code 53852, *Transurethral destruction of prostate tissue; by radiofrequency thermotherapy*, is a new code for an emerging technology and is rarely performed in the U.S. Because this is a new technology it is difficult to make comparisons with existing procedures. The RUC felt that 53850 could best be compared to 53850, *Transurethral destruction of prostate tissue; by microwave thermotherapy*, another emerging technology. Both codes are new approaches to treating patients with benign prostatic hyperplasia (BPH). Patients with BPH most commonly undergo a transurethral resection of the prostate which is described by CPT codes 52601, 52612, and 52614. Surveys showed a median RVU of 9.92 and an intra-service time of 57.5 minutes for 53852 and a median RVU of 9.58 and an intra-service time of 90 minutes for 53850. The RUC recommended a value of 9.58 RVUs for 53850 at its' February 1997 meeting and concludes that 53852 should be valued the same. Therefore the RUC recommends that 53852 should be valued at 9.58 RVUs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•53850	J1	Transurethral destruction of prostate tissue; by microwave thermotherapy	090	9.58
•53852	J2	by radiofrequency thermotherapy	090	9.58

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

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

CPT Code: 5246X Tracking Code: J1 Global Period: 090 Recommended RVW: 9.58

CPT Descriptor: Transurethral Microwave Thermotherapy (TUMT)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Typical Patient: 66-year old male, suffering from mild to moderate prostatic obstruction. Responded insufficiently to watchful waiting and medical therapies, such as alpha blockers and 5 alpha reductase inhibitors. Patient seeks alternative to more invasive surgical prostatic procedures.

Description of Pre-Service Work:

Includes services provided from the day before the surgery or diagnostic procedure until the time of the procedure and may include: (1) obtaining and reviewing records or previous history, laboratory studies and urologic x-rays before the procedure; (2) communicating with other health professionals (e.g. family physician, anesthesiologist); (3) communicating with the patient to explain the procedure, operative risks and benefits and to obtain informed consent; (4) dressing for surgery, positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery or procedure and any other non "skin-to-skin" work in the operating room or 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:

May include: (1) Positioning and prepping the patient and inserting Lidocaine jelly. (2) Placing the red rubber catheter to completely drain the bladder. (3) Inserting the treatment catheter and prostatoprobe. (4) Positioning patient in the lateral decubitus position to perform transrectal sonography. (4) Measuring the patient's prostate length and checking position of treatment catheter balloon. (5) Removing ultrasound probe and securing and positioning rectal sensor. (6) Repositioning patient supine. (7) Connecting prostatoprobe to the microwave machine. (8) Replacing ultrasound probe with a suprapubic probe to monitor prostatoprobe in the bladder (every 15 minutes). (9) Waiting for urethral temperature to return to normal (10) Removing catheters and disconnecting probes from the machine and the patient.

Description of Post-Service Work:

Some of the following may apply: (1) all post procedure care on the day of the procedure, and if applicable patient stabilization, post-operative orders, communication with the patient and/or family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the operating room; (2) all post-operative hospital visits and discharge day management; (3) 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 evaluation of periodic labor reports and medication adjustment)

The patient is dismissed when felt appropriate by the physician.

SURVEY DATA:

Specialty: American Urological Association

Sample Size: 35 Response Rate (%): 72% (28/35) Median RVW: 9.58

25th Percentile RVW: 8.79 75th Percentile RVW: 10.49 Low: 6.50 High: 12.00

Median Pre-Service Time: 60 minutes Median Intra-Service Time: 90 minutes25th Percentile Intra-Svc Time: 75 minutes 75th Percentile Intra-Svc Time: 90 minutes Low: 60 minutes
High: 120 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>0 minutes</u>	<u>0 visits</u>
Office:	<u>30 minutes</u>	<u>2 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	52601	Transurethral electrosurgical resection of the prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	11.51
2)	50590	Lithotripsy, extracorporeal shock wave	9.62 (*96 value)

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
52601	60 minutes	60 minutes	50 minutes; 0 ICU; 2 37.5-min other hosp; 2 60-min other office	4	4	3
50590	60 minutes	60 minutes	45 minutes; 0 ICU; 0 other hosp; 2 30-min other office	2.5	2	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? CPT 52601, 52612, and 52614

How often do physicians in your specialty perform this service? Commonly Sometimes XX Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 50,000

Is this service performed by many physicians across the United States? Yes X No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 524X2 Tracking Number: J2 Global Period: 090 Recommended RVW: 9.92

CPT Descriptor: Transurethral destruction of prostate tissue by radio frequency thermotherapy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66 year-old man with BPH and difficulty urinating. His symptoms have failed to improve on medical therapy (alpha blockers and Finasteride). After discussion of surgical treatment options, he has elected a transurethral destruction of prostate tissue using radio frequency thermotherapy procedure. Prior to the procedure (a week or more), transrectal prostate ultrasound and cystoscopy are done in the office to assess prostate size and plan treatment. *(These are billed separately from, and in addition to, the "TUNA" procedure).*

Description of Pre-Service Work: Includes services provided from the day before surgery until the time of the procedure and may include: (1) obtaining and reviewing hospital admission 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: consultation and evaluation, at which time the decision to provide the procedure was made.

Description of Intra-Service Work: The patient is on the cystoscopy table (in the office, surgery center or hospital), usually under local anesthesia and sedation (but may be under regional or general anesthesia). The "TUNA" device is inserted through the urethra under direct vision, and the electrodes are inserted into the first treatment area of the prostate (as the treatment plan has previously determined). The radio frequency (RF) generator is turned on for a total of about 5 ½ minutes to raise the prostate to the proper temperature. The electrodes are then retracted and re-positioned into the second treatment. A typical prostate requires 4 to 10 treatments. A catheter is passed and the bladder is drained.

Description of Post-Service Work: Includes the following: (1) all post-operative care 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 room; (2) monitoring the patient in the out-patient department 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:

Specialty: American Urological Association

Sample Size: 65 Response Rate (%): (24/65) 36% Median RVW: 9.92

25th Percentile RVW: 9.00 75th Percentile RVW: 11.63 Low: 4.50 High: 13.50

Median Pre-Service Time: 60 minutes Median Intra-Service Time: 57.5 minutes

25th Percentile Intra-Svc Time: 45 minutes 75th Percentile Intra-Svc Time: 60 minutes Low: 30 minutes
High: 90 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>45 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>0 minutes</u>	<u>0 visits</u>
Office:	<u>45 minutes</u>	<u>3 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	52647	Non-contact laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	9.84
2)	52601	Transurethral electro-surgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	11.51

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-time	Median Intra-time	Median Post-time	Median Mental Effort/Judgement	Median Tech Skill	Median Psych Stress
524X2	60 min.	60 min.	45 min.	3	3	3
52601	52.5 min.	55 min.	30 min.	3	3.5	3
52647	52.5 min.	30 min.	30 min.	3	3	3

FREQUENCY INFORMATION

How was this service previously reported? CPT 53899 - unlisted urological procedure

How often do physicians in your specialty perform this service? Commonly Sometimes XX Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Unsure. However, the manufacturer that made the request for the CPT code, Vida-Med, reports that approximately 500,000 of these procedures will be performed.

Is this service performed by many physicians across the United States? Yes XX No

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
FEBRUARY 1997

Lymphocele Drainage - Tab 22

The work described by the new code 49062 describes the open drainage of a lymphocele. Although this procedure does not represent new technology the new code will more adequately describe that services that are involved. The typical patient usually develops lymphoceles as a result of renal transplant surgery or retropubic prostatectomy. This procedure is equivalent in terms of work to CPT code 49060 *Drainage of peritoneal abscess* (work RVU = 10.55). Since the conditions that result in this type of surgery are uncommon, the procedure is performed on a relatively limited basis. Although this procedure achieves the same result as percutaneous abscess drainage, the patient undergoing the procedure described by 49062 has failed the percutaneous procedure. When a patient presents for surgery, the surgeon will determine based on their skill and experience whether or not the procedure should be performed as an open or laparoscopic procedure. The RUC recommended an RVU of 10.78 for this procedure which was based on a survey median from over 30 urologists.

A new code 56314 was added for laparoscopic lymphocele drainage. This work involved in this procedure is the same as the open lymphocele drainage and involves similar patients. This procedure is based on the experience of the surgeon not the availability of the technology. The RUC recommended an RVU of 8.93 which was based on a survey median from over 30 urologists.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•49062	CC1	Drainage of extraperitoneal lymphocele to peritoneal cavity, open	090	10.78
•56314	CC2	Laparoscopy, surgical; with drainage of lymphocele to peritoneal cavity	010	8.93

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

CPT Code: 49XXX Tracking Number: CC1 Global Period: 090 Recommended RVW: 10.78

CPT Descriptor: Drainage of extraperitoneal lymphocele to peritoneal cavity, open

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year old man is 18 months post-operative radical retro-pubic prostatectomy and bilateral pelvic lymphadenectomy for the treatment of localized prostate cancer. He has recently developed pelvic pain and urinary urgency and frequency. Ultrasound reveals a large lymphocele. Percutaneous (needle) drainage is attempted without success. Because of previous multiple abdominal surgical procedures laparoscopic approach is not indicated. Open drainage of lymphocele is elected.

Description of Pre-Service Work: Includes services provided from the day before the surgery until the time of the procedure and may include: (1) obtaining and reviewing hospital admission laboratory studies and urologic x-rays before the procedure; (2) communicating with other health care professionals (e.g., family physician, anesthesiologist); (3) communicating with the patient to explain operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (e.g., placing of central arterial and venous lines, administering general, spinal and/or epidural anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery and any other non "skin-to-skin" work in the operating room. Does not include: Consultation or evaluation at which the decision to provide the procedure was made.

Description of Intra-Service Work: Under general anesthesia, a midline abdominal incision is made and the abdomen is entered. The lymphocele is identified in the retroperitoneum of the pelvis. The lymphocele is entered using electrocautery. The peritoneum and its attached lymphocele wall are grasped and an incision is extended circumferentially. The ellipse of the lymphocele wall is removed creating a 7 x 3 cm window, the edge of the lymphocele is coagulated and sutured, all loculations are lysed to create a single cavity. The abdomen is then closed.

Description of Post-Service Work: Includes the following: (1) all post-operative care 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 room; (2) all post-operative hospital visits and discharge day management; (3) 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 evaluation of periodic laboratory reports and medication adjustment)

SURVEY DATA:

Specialty: American Urological Association

Sample Size: 27 Response Rate (%): 74% (20/27) Median RVW: 10.78

25th Percentile RVW: 10.00 75th Percentile RVW: 12.50 Low: 9.50 High: 17.00

Median Pre-Service Time: 90 minutes Median Intra-Service Time: 90 minutes

25th Percentile Intra-Svc Time: 60 minutes 75th Percentile Intra-Svc Time: 90 minutes Low: 45 minutes High: 180 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>42.5 minutes</u>	<u>3 visits</u>
Office:	<u>20 minutes</u>	<u>2 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	38770	Pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes (separate procedure)	12.10
2)	49060	Drainage of retroperitoneal abscess	10.55
3)	51525	Cystotomy; for excision of bladder diverticulum, single or multiple (separate procedure)	12.78

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
38770	90 minutes	90 minutes	Day of Svc 30 min; 0 ICU; 3 40-min other hosp.; 2 20-min other office	3	3	3
49060	75 minutes	60 minutes	Day of Svc 30 min; 0 ICU; 4 60-min other hosp.; 3 37.5-min other office	3	3	3
51525	120 minutes	90 minutes	Day of Svc 30 min; 0 ICU; 5 60-min other hosp; 2 30-min other office	3	3	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? CPT 38308

How often do physicians in your specialty perform this service? Commonly XX Sometimes
Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 2,759.88

Is this service performed by many physicians across the United States? Yes XX No

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

CPT Code: 563XX Tracking Number: CC2 Global Period: 010 Recommended RVW: 8.93

CPT Descriptor: Laparoscopy, surgical; with drainage of lymphocele to peritoneal cavity

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year old man is 18 months post-operative radical retropubic prostatectomy and bilateral pelvic lymphadenectomy for the treatment of localized prostate cancer. He has recently developed pelvic pain and urinary urgency and frequency. Ultrasound reveals a large lymphocele. Percutaneous (needle) drainage is attempted without success. Laparoscopic approach is elected.

Description of Pre-Service Work: Includes services provided from the day before the surgery until the time of the procedure and may include: (1) obtaining and reviewing hospital admission laboratory studies and urologic x-rays before the procedure; (2) communicating with other health care professionals (e.g., family physician, anesthesiologist); (3) communicating with the patient to explain operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (e.g., placing of central arterial and venous lines, administering general, spinal and/or epidural anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery and any other non "skin-to-skin" work in the operating room. Does not include: Consultation or evaluation at which the decision to provide the procedure was made.

Description of Intra-Service Work: Under general anesthesia, a needle is inserted into the peritoneal cavity and a pneumoperitoneum is created. An appropriate number of trocar operating sheaths are placed. The lymphocele is visualized in the pelvis as two extrinsic bulges in the retroperitoneum. The lymphocele is entered using electrocautery and leakage of fluid confirms the location. The peritoneum and the attached lymphocele all are grasped and an incision is made using scissors. The ellipse of the lymphocele wall is removed creating a 7 cm x 3 cm window. The cavity is irrigated and is inspected for hemostasis. The abdomen is deflated and all trocars are removed. The wounds are surgically closed.

Description of Post-Service Work: Includes the following: (1) all post-operative care 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 room; (2) all post-operative hospital visits and discharge day management; (3) all post-discharge office visits for this procedure for 10 days after the day of the operation are considered part of the post-operative work for this procedure (including evaluation of periodic laboratory reports and medication adjustment)

SURVEY DATA:

Specialty: American Urological Association

Sample Size: 27 Response Rate (%): 74% (20/27) Median RVW: 8.93

25th Percentile RVW: 7.25 75th Percentile RVW: 10.00 Low: 5.25 High: 14.25

Median Pre-Service Time: 75 minutes Median Intra-Service Time: 90 minutes

25th Percentile Intra-Svc Time: 77.50 minutes 75th Percentile Intra-Svc Time: 120 minutes
 Low: 50 minutes High: 180 minutes

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30 minutes</u>	
ICU:	<u>0 minutes</u>	<u>0 visits</u>
Other Hospital:	<u>30 minutes</u>	<u>2 visits</u>
Office:	<u>35 minutes</u>	<u>2 visits</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	56311	Laparoscopy surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple	8.93
2)	56312	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy	12.06
3)	56303	Laparoscopy surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method	5.69

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
56311	90 minutes	90 minutes	30-min day of svc; 0 ICU visits; 2 30-min other hosp; 2 25-min other office	3	3	4
56312	60 minutes	120 minutes	30-min day of svc; 0 ICU visits; 2.5 37.5-min. other hosp; 1.5 25-min other office	3	3	3.5
56303	75 minutes	90 minutes	50-min day of svc; 0 ICU visits; 1 30-min other hosp; 2 30-min other office	3	4	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

How was this service previously reported? CPT 56399

How often do physicians in your specialty perform this service? Commonly XX Sometimes
Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 654

Is this service performed by many physicians across the United States? Yes XX No

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Ganciclovir Implant - Tab 28

A new CPT code was added for the implantation of an intravitreal drug delivery system. The most common implant is ganciclovir which is used in the treatment of CMV retinitis, a disease that is associated with AIDS patients. In the absence of a CPT code to report this service physicians have been using the unlisted procedure code 67299. The specialty society reported that due to the success of ganciclovir and its recent FDA approval, it is expected that more physicians will be reporting this procedure. The specialty society noted that the work involved in 67027, *Implantation of intravitreal drug delivery system, include concomitant removal of vitreous (eg, ganciclovir implant)* is less intense than vitrectomy procedures such as 67036 which has an RVU of 11.33.

Based on a survey of 40 ophthalmologists, the RUC recommended an RVU of 10.35 for code 67027.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•67027	EE1	Implantation or replacement of intravitreal drug delivery system (eg, ganciclovir implant), includes concomitant removal of vitreous (For removal, see 67121)	090	10.35

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

CPT Code: 670XX Tracking Number: _____ Global Period: 090 Recommended RVW: 10.35

CPT Descriptor: Implantation or replacement of intravitreal drug delivery system, includes concomitant removal of vitreous (eg, ganciclovir implant)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used In Survey: A 40-year old HIV positive man presents with CMV retinitis in one eye. After discussion of available treatment options, the patient chooses the Ganciclovir implant for treatment of his disease. His medical History is reviewed, his case discussed with his primary care provider, and laboratory tests are reviewed to insure that surgery would indeed be appropriate. The patient is taken to the operating room where the procedure is performed using a retrobulbar block and IV sedation. A partial vitrectomy is performed through a pars plana incision and a Ganciclovir implant placed into the eye and sutured into position. The patient requires frequent post-operative evaluation including monthly evaluations for the status of his CMV retinitis both in the involved eye and for disease elsewhere.

Description of Pre-Service Work: The patient's history and examination findings are reviewed. Written informed consent for the procedure is obtained. This procedure includes a discussion of the benefits and significant risks including retinal detachment. Laboratory test results are obtained and reviewed to confirm that the patient is a surgical candidate. Similarly, physical exam results from the primary care physician are reviewed to be certain the patient remains a candidate for this procedure. The patient is taken to the operating room and placed in the supine position. A retrobulbar injection is given and IV sedation administered. Routine sterile prep and drape is performed.

Description of Intra-Service Work: On a side table the Ganciclovir implant is prepared. It is removed from the sterile package, a small hole is placed through the strut with a 30-gauge needle, the excess strut trimmed, and the hole threaded with a double armed 8-0 nylon suture. A lid speculum is placed between the eyelids and the operating microscope is positioned over the eye to perform the procedure. The conjunctiva is opened inferotemporally for approximately 3 clock hours. Hemostasis is maintained with bipolar cautery. A stab incision into the eye is made 4mm from the limbus and continued circumferentially for 52 to 6mm. The choroid is opened to a similar length. The vitreous cutter is placed inside the wound and a partial vitrectomy performed. The Ganciclovir implant is inserted through the wound and sutured into position using the double armed 8-0 nylon suture. Prolapsed vitreous is removed using the vitreous cutter. The wound is then closed with 8-0 nylon suture. The eye is filled to a normal pressure with balanced salt solution on a 30-gauge needle. The pressure of the eye is confirmed with gentle palpation of the globe. The conjunctiva is closed with a 6-0 plain suture. The retina is inspected with the indirect ophthalmoscope (ophthalmoscopy) to insure that there have been no retinal breaks. The ophthalmoscopic exam will also confirm that the implant is well positioned outside of the visual axis. Subconjunctival antibiotics are administered. After an appropriate recovery period, the patient is discharged home usually on the same day. At the time of the discharge, the physician discusses the warning symptoms of retinal detachment and endophthalmitis. He/she also reviews the use of topical antibiotics and corticosteroids the patient will be administering at home.

CPT Code: 670xx

Description of Post-Service Work: Patients are evaluated on post-operative day one, day seven, one month and monthly thereafter. Each exam consists of vision, slit lamp evaluation, intraocular pressure determination and retinal ophthalmoscopy of the operated eye. Specific attention is directed to the state of the CMV retinitis in the eye and to the retina for evidence of retinal tears or detachment. At each exam, recommendations regarding management of systemic anti-CMV medications are often made and communicated with the patient's primary care provider. Follow-up during the 90 day period is more frequent than with most other forms of ocular surgery due to the necessity to continue monitoring the infectious disease, even after the surgical wounds are well healed.

SURVEY DATA:Specialty: American Academy of OphthalmologySample Size: 120 Response Rate (%): 33% Median RVW: 11.5425th Percentile RVW: 9.50 75th Percentile RVW: 14.00 Low: 4.30 High: 19.90Median Pre-Service Time: 60 minutes Median Intra-Service Time: 60 minutes25th Percentile Intra-Svc Time: 45 min. 75th Percentile Intra-Svc Time: 83 min. Low: 20 High: 180

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30 min.</u>	
ICU:	<u>-</u>	
Other Hospital:	<u></u>	
Office:	<u>90</u>	<u>5</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	67036	Vitrectomy, mechanical pars plana approach	11.33
2)	65260	Removal of foreign body, intraocular; from Posterior segment, magnetic extraction, anterior or posterior route	10.35

CPT Code: 670xx

- 3) 67010 Removal of vitreous, subtotal removal with mechanical vitrectomy 6.67
- 4) 67121 Removal of implanted material, posterior; segment; intraocular 10.17

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgment; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgment	Median Technical Skill & Physical Effort	Median Psychological Stress
670XX	60	60	120	3.8	3.7	4.1
67036				3.7	3.9	3.8

ADDITIONAL RATIONALE:

The Diagnostic & Procedural Terminology and Reimbursement Committee of the American Academy of Ophthalmology recently completed a survey of the relative work value of a new procedure for implantation of an intravitreal drug delivery device, 6702X. The Committee noted that the median work value from the survey data was 11.54 RVWs. The Committee believes that this value slightly overstates the relative work value of the procedure. The Committee believes that when compared to the key reference procedure, 67036 (Pars plana vitrectomy), there is less mental judgment associated with the performance of this procedure as there is no removal of the posterior vitreous, a difficult and integral part of the reference procedure. The Committee also noted that there is less intra service time with the proposed code than with 67036. In general we felt that this new procedure is less difficult than 67036 as there is only one incision instead of three incisions and the vitrectomy is performed anteriorly rather than posteriorly near the retina. The Committee noted that the estimates of 30 minutes of post-service work on the day of procedure are high. The Committee did, however, note that there is higher stress with the new procedure, 6702X, due to a much higher iatrogenic rate of retinal detachment following this procedure than with 67036.

In light of these observations and survey data, the Committee felt that the relative work value should be reduced from that found in the survey. We would suggest that the value of the procedure as currently described in CPT needs to be slightly less than that of 67036 which has

CPT Code: 670xx

11.33 RVWs. A much more suitable comparison reference procedure is **65260 - Removal of foreign body, intraocular; from posterior segment, magnetic extraction anterior posterior route**. This procedure has 10.35 RVWs. The procedure includes the same type of vitrectomy, the same incision as the implantation of a drug delivery device, and a nearly comparable physician stress.

The Committee proposes that 10.35 RVWs is a suitable relative work value for the implantation of an intravitreal drug delivery device.

FREQUENCY INFORMATION

How was this service previously reported? 67036-52, 67299

How often do physicians in your specialty perform this service? Commonly Sometimes ☒ Rarely

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

Is this service performed by many physicians across the United States? Yes ☒ No

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Bone Density Studies - Tab 29

CPT codes 76070, 76075, 78350, and 78351 were only editorially changed. The current work relative values for these codes should be retained. Codes 76076, *Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)*, and 76078, *Radiographic absorptiometry photodensitometry), one or more sites*, are new codes used to study bone density. The survey data showed a median RVU of 0.30 for 76076 and a median RVU of 0.26 for 76078. The RUC expressed concern that some portion of the work for these services is performed by a technician and as such the recommended RVUs are too high. The RUC believes that 76076 should be compared to 71020, *Radiologic examination, chest, two views, frontal and lateral* (RVU=0.22), and recommends that the relative value should be the same. The RUC sees that the surveyed proportional relationship between 76076 and 76078 should be maintained. Thus, the RUC recommends that 76076 should be valued at 0.22 RVUs and 76078 should be valued at 0.20 RVUs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
76070	AB1	Computerized tomography bone mineral density study, <u>one or more sites</u>	XXX	0.25 (no change)
76075	AB2	Dual energy x-ray absorptiometry (DEXA), bone density study, <u>one or more sites; axial skeleton (eg, hips, pelvis, spine)</u>	XXX	0.30 (no change)
•76076	AB3	appendicular skeleton (peripheral) (eg, radius, wrist, heel)	XXX	0.22
•76078	AB4	Radiographic absorptiometry photodensitometry), one or more sites	XXX	0.20
78350	AB5	Bone density (bone mineral content) study; <u>one or more sites</u> ; single photon absorptiometry	XXX	0.22 (no change)
78351	AB6	dual photon absorptiometry, <u>one or more sites</u>	XXX	0.30

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<i>(78380, 78381 have been deleted. To report, see 78300, 78305)</i> (For radiographic bone density (photodensitometry), use 76078)		(no change)

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

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION
American College of Radiology (ACR)
Society of Nuclear Medicine (SNM)
American College of Rheumatology (ACR_h)

CPT Code: 760X1 Tracking Number: AB3 Global Period: XXX Recommended RVW: 0.30

CPT Descriptor: Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites,
appendicular skeleton (peripheral) (eg, radius, wrist, heel)

CLINICAL DESCRIPTION OF SERVICE:

Vignettes Used in Survey:

A thirty-five year-old woman with kidney stones secondary to hyperparathyroidism. Family history is positive for her father having osteoporosis.

A forty year-old female marathon runner with recurrent tibial stress fractures. Her history reveals a low calcium diet and amenorrhea.

A fifty-eight year-old male with corticosteroid dependent Rheumatoid Arthritis and rib fractures from playing golf.

A seventy-three year-old woman with a recent hip fracture.

A seventy year-old woman, who is undergoing estrogen replacement therapy for osteoporosis, is referred for therapy progress/disease-monitoring purposes.

A sixty-two year-old woman with a height loss and a family history of osteoporosis.

Description of Physician Work Associated With This Procedure:

Pre-Service Physician Work:

- Review history and physical exam
- Discuss procedure with patient

Intra-Service Physician Work:

- Interprets results of study
- Compares results in relation to current diagnosis and future treatment, if appropriate

Post-Procedure Physician Work:

- Dictate, correct, and sign report
 - Discuss and communicate report/findings with referring physician(s)
-

SURVEY DATA:

Specialty: Combined Data (ACR, SNM, ACRh)Sample Size: 255 Response Rate (%): N = 29 (11.4%) Median RVW: 0.3025th Percentile RVW: 0.26 75th Percentile RVW: 0.49 Lowest RVW: 0.17 Highest RVW: 1.15Median Total Service Time: 10 minutes25th Percentile Total Service Time: 5 minutes75th Percentile Total Service Time: 18 minutesLowest Total Service Time: 2 minutesHighest Total Service Time: 30 minutes

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>1997 RVW</u>	<u>Societies</u>
1) 76070	Computerized tomography bone mineral density study, <u>one or more sites</u>	.25	ACR/SNM/ACRh
2) 76075	Dual energy x-ray absorptiometry (DEXA), bone density study, <u>one or more sites</u>	.30	ACR/SNM/ACRh

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

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Total Time	Median Mental Effort & Judgment	Median Technical Skill & Physical Effort	Median Psychological Stress
	ACR/SNM/ACRh	ACR/SNM/ACRh	ACR/SNM/ACRh	ACR/SNM/ACRh
760X1	10	3	3	2
76075	10	3	2	2
76070	5	2	2	1

ACR/SNM/ACRh

Number of times performed in last 12 months (median)	100
Agree with vignette?	Yes (85%, N=11) No (15%, N=2)

ADDITIONAL RATIONALE

The recommended RVW is based on the median RVW of the combined (ACR, SNM, ACRh) data base.

FREQUENCY INFORMATION

How was this service previously reported? 76075

How often do physicians in your specialty perform this service?

Commonly ☐ Sometimes ☒ Rarely ☐

Estimate the number of times this service might be performed nationally
in a one-year period? unable to quantify

Is this service performed by many physicians across the United States? Yes ☒ No ☐

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION
American College of Radiology (ACR)
Society of Nuclear Medicine (SNM)
American College of Rheumatology (ACR_h)

CPT Code: 760X2 Tracking Number: AB4 Global Period: XXX Recommended RVW: 0.26

CPT Descriptor: Radiographic absorptiometry (photodensitometry), one or more sites

CLINICAL DESCRIPTION OF SERVICE:

Vignettes Used in Survey:

A thirty-five year-old woman with kidney stones secondary to hyperparathyroidism. Family history is positive for her father having osteoporosis.

A forty year-old female marathon runner with recurrent tibial stress fractures. Her history reveals a low calcium diet and amenorrhea.

A fifty-eight year-old male with corticosteroid dependent Rheumatoid Arthritis and rib fractures from playing golf.

A seventy-three year-old woman with a recent hip fracture.

A seventy year-old woman, who is undergoing estrogen replacement therapy for osteoporosis, is referred for therapy progress/disease-monitoring purposes.

A sixty-two year-old woman with a height loss and a family history of osteoporosis.

Description of Physician Work Associated With This Procedure:

Pre-Service Physician Work:

- Review history and physical exam
- Discuss procedure with patient

Intra-Service Physician Work:

- Interprets results of study
- Compares results in relation to current diagnosis and future treatment, if appropriate

Post-Procedure Physician Work:

- Dictate, correct, and sign report
 - Discuss and communicate report/findings with referring physician(s)
-

SURVEY DATA:Specialty: Combined Data (ACR, SNM, ACRh)Sample Size: 255 Response Rate (%): N = 14 (5.5%) Median RVW: 0.2625th Percentile RVW: 0.20 75th Percentile RVW: 0.45 Lowest RVW: 0.10 Highest RVW: 1.0Median Total Service Time: 10 minutes25th Percentile Total Service Time: 5 minutes75th Percentile Total Service Time: 15 minutesLowest Total Service Time: 1 minutesHighest Total Service Time: 20 minutes

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>1997 RVW</u>	<u>Societies</u>
1) 76070	Computerized tomography bone mineral density study, <u>one or more sites</u>	.25	ACR/SNM/ACRh
2) 76075	Dual energy x-ray absorptiometry (DEXA), bone density study, <u>one or more sites</u>	.30	ACR/SNM/ACRh

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

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Total Time	Median Mental Effort & Judgment	Median Technical Skill & Physical Effort	Median Psychological Stress
	ACR/SNM/ACRh	ACR/SNM/ACRh	ACR/SNM/ACRh	ACR/SNM/ACRh
760X2	10	2.5	2	2
76070	5	2.5	3	1
76075	12.5	4	2	3

ACR/SNM/ACRh

Number of times performed in last 12 months (median)	100
Agree with vignette?	Yes (100%)

ADDITIONAL RATIONALE

The recommended RVW is based on the median RVWs from the combined (ACR, SNM, ACRh) data base.

FREQUENCY INFORMATION

How was this service previously reported?

How often do physicians in your specialty perform this service?

Commonly ____ Sometimes X Rarely ____

Estimate the number of times this service might be performed nationally
in a one-year period? unable to quantify

Is this service performed by many physicians across the United States? Yes X No ____

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

For: American Association of Clinical Endocrinologists

CPT Code: 760X1 Tracking Number: _____ Global Period: XXX Recommended RVW: 0.30

CPT Code Descriptor: Dual energy X-ray absorptiometry (DEXA), bone density study, one or more sites, appendicular skeleton (peripheral), e.g., radius, heel, wrist.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A seventy year old woman is concerned about the possibility of osteoporosis. She has never taken estrogen. Her mother had a hip fracture. She is healthy and has not lost height.

A fifty year old early menopausal woman who has a family history of breast cancer is debating whether or not to initiate estrogen replacement therapy.

Description of Pre-Service Work:

- Review history and physical examination
- Review risk factors for osteoporosis
- Review other clinical data such as lab work and radiology procedures
- Determine appropriate procedure to be done
- Discuss procedure with patient

Description of Intra-Service Work:

- Supervision of proper patient positioning and quality control by technician
- Validate quantitative data
- Interpret quantitative data

Description of Post-Service Work:

- Dictate, correct, sign report of results, interpret results/findings and therapeutic options, and follow-up recommendations.
- Communicate report to referring physician and/or patient

SURVEY DATA:

Specialty: Endocrinology

Sample Size: 172 Response Rate (%): 7.6% Median RVW: 0.30

25th Percentile RVW: 0.245 75th Percentile RVW: 0.43 Low: 0.12 High: 1.0

Median Pre-Service Time: 5 Median Intra-Service Time: 5

25th Percentile Intra-Svc Time: 1.5 75th Percentile Intra-Svc Time: 7.5 Low: 0 High: 15

Median Post-Service Time: _____ Total Time _____ Number of Visits _____

Day of Procedure: 10

ICU: _____

Other Hospital: _____

Office: _____

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
76075	DEXA bone density, one or more sites, axial	0.30
76070	Computerized tomography bone density	0.25
78350	Single photon absorptiometry bone density	0.22
78006	Thyroid imaging with uptake, single determination	0.51
76091	Mammography, bilateral	0.42
72100	Radiologic examination, spine, LS, AP and lat	0.22

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress

ADDITIONAL RATIONALE**FREQUENCY INFORMATION**

How was this service previously reported? 76075

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

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

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Cervical or Vaginal Cytopathology - Tab 30

The specialty society reported that a new code 88141, *Cytopathology, cervical or vaginal, (any reporting system; requiring interpretation by the physician)* was added to CPT that will replace the work involved in the Pap smear interpretation codes 88151 and 88157, which will be deleted. The specialty noted that this change should be considered editorial and does not involve a change in physician work. The specialty recommended that the current value of the pap smear interpretation code of 0.42 RVUs be maintained for the new code 88141. The RUC agreed with the specialty society and recommend an RVU of 0.42 for CPT code 88141.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
88108	AC1	<u>Cytopathology</u> , concentration technique, smears and interpretation (eg, Saccomonno technique)	XXX	0.56 (no change)
•88141	AC2	Cytopathology, cervical or vaginal, (any reporting system); requiring interpretation by physician (List separately in addition to code for technical service) (To report technical component, see 88142, 88150, 88152, 88155, 88156-88158)	ZZZ	0.42
•88142	AC3	Cytopathology, cervical or vaginal, (any reporting system) collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	XXX	N/A
88150		Cytopathology, smears, cervical or vaginal, up to three smears; screening by technician under physician supervision	XXX	N/A

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CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
88151	AC4	requiring interpretation by physician (88151 has been deleted. To report see 88141)	XXX	N/A
•88152	AG5	with manual cytotechnologist screening and automated rescreening under physician supervision	XXX	N/A
88156		Cytopathology, smears, cervical or vaginal (the Bethesda System (TBS)), up to three smears; screening by technician under physician supervision	XXX	N/A
88157	AG6	requiring interpretation by a physician (88157 has been deleted. To report see 88141)	XXX	N/A
•88158	AG7	with manual cytotechnologist screening and automated rescreening under physician supervision	XXX	N/A

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Pulmonary Artery Angioplasty - Tab 31

New codes were added to CPT to report the work involved in pulmonary artery angioplasties. Pulmonary artery angioplasty is used primarily to treat patients that are suffering from pulmonary artery stenosis which is caused by congenital heart disease. The specialty societies reported that these procedures are performed rarely, approximately 400 were performed in 1996. Currently, these procedures are reported using CPT code 35476 which is a percutaneous transluminal balloon angioplasty code. The specialty societies also noted that these procedures are complex and require that the pulmonary artery be dilated at more than one stage to ensure cardiac output.

During their deliberations, the RUC believed that the specialty societies recommendations were too high for these codes, and determined that because the work of these procedures is similar, CPT codes 92997, *Percutaneous transluminal balloon angioplasty; single vessel* and 92998, *Percutaneous transluminal balloon angioplasty; each additional vessel* should have relative values more in the range of the current coronary angioplasty codes, CPT codes 92982 (10.98 RVUs) and 92984 (2.97 RVUs). The RUC recommended an RVU of 12.00 for code 92997 and an RVU of 6.00 for code 92998. Code 92998 was valued as a single vessel procedure by the RUC.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•92997	XX1	Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel	000	12.00
•92998	XX2	each additional vessel	ZZZ	6.00

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

CPT Code: 9XXX1 Tracking Number: XX1 Global Period: 000 Recommended RVW: 19.93

CPT Descriptor: Percutaneous transluminal balloon angioplasty; single vessel

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: This is a six year old female with a history of tetralogy of Fallot who has previously undergone repair including patching of her branch pulmonary arteries for pulmonary artery stenosis. She presents to the Cath Lab at this time with recurrent obstruction of both branch pulmonary arteries for assessment and pulmonary angioplasty. The patient was brought to the Cath Lab and was sedated with IV morphine and Versed. After hemostasis was obtained complete hemodynamic and angiographic assessment was performed. This confirmed severe stenosis of both proximal branch pulmonary arteries. A 7F endhole catheter was positioned in the distal left and right pulmonary artery and a .035 inch Rosen wire was positioned into the LPA. The endhole catheter was removed and replaced with a 12mm 2cm ultrathin balloon. Balloon angioplasty was then performed to the proximal branch pulmonary arteries. Following successful completion of this procedure repeat angiography was performed to confirm improvement in the areas of stenosis and repeat hemodynamic measurements were obtained. After satisfactory results were obtained the catheters and sheaths were removed and the patient was transferred back to the floor in good condition.

SURVEY DATA:

Specialty: American Academy of Pediatrics & American College of Cardiology

Sample Size: 200 Response Rate (%): 18 % Median RVW: 19.93

25th Percentile RVW: 18 75th Percentile RVW: 20.6 Low: 9.5 High: 52

Median Pre-Service Time: 60 Median Intra-Service Time: 155

25th Percentile Intra-Svc Time: 120 75th Percentile Intra-Svc Time: 180 Low: 30 High: 300

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>60</u>	<u> </u>
ICU:	<u>20</u>	<u>1</u>
Other Hospital:	<u>30</u>	<u>1</u>
Office:	<u>20</u>	<u>1</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	92990	Revision of Pulmonary Valve	16.22
2)	92986	Revision of Aortic Valve	20.34
3)	92995	Coronary Atherectomy	12.09
4)	92982	Coronary Artery Dilation	10.98

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
92990	45	100	60	3	3	3
92986	60	120	90	4	4	4.25

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? 35476

How often do physicians in your specialty perform this service? ___ Commonly X Sometimes ___ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 500

Is this service performed by many physicians across the United States? ___ Yes X No

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

CPT Code: 9XXX2 Tracking Number: XX2 Global Period: ZZZ Recommended RVW: 11.25

CPT Descriptor: Percutaneous transluminal balloon angioplasty; each additional vessel

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: This is a six year old female with a history of tetralogy of Fallot who has previously undergone repair including patching of her branch pulmonary arteries for pulmonary artery stenosis. She presents to the Cath Lab at this time with recurrent obstruction of both branch pulmonary arteries for assessment and pulmonary angioplasty. The patient was brought to the Cath Lab and was sedated with IV morphine and Versed. After hemostasis was obtained complete hemodynamic and angiographic assessment was performed. This confirmed severe stenosis of both proximal branch pulmonary arteries. A 7F endhole catheter was positioned in the distal left and right pulmonary artery and a .035 inch Rosen wire was positioned into the LPA. The endhole catheter was removed and replaced with a 12mm 2cm ultrathin balloon. Balloon angioplasty was then performed to the proximal branch pulmonary arteries. Following successful completion of this procedure repeat angiography was performed to confirm improvement in the areas of stenosis and repeat hemodynamic measurements were obtained. After satisfactory results were obtained the catheters and sheaths were removed and the patient was transferred back to the floor in good condition.

SURVEY DATA:

Specialty: American Academy of Pediatrics & American College of Cardiology

Sample Size: 200 Response Rate (%): 18 % Median RVW: 11.25

25th Percentile RVW: 3 75th Percentile RVW: 10 Low: .14 High: 30

Median Pre-Service Time: 30 Median Intra-Service Time: 57.51

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 180 Low: 20 High: 360

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>30</u>	<u> </u>
ICU:	<u>20</u>	<u>1</u>
Other Hospital:	<u>30</u>	<u>1</u>
Office:	<u>30</u>	<u>1</u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	92990	Revision of Pulmonary Valve	16.22
2)	92986	Revision of Aortic Valve	20.34
3)	92995	Coronary Athectomy	12.09
4)	93501	Right Heart Catheterization	3.02

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
92990	42.5	110	55	3	3	3
92986	60	115	60	4	4	4

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? 35476

How often do physicians in your specialty perform this service? ___Commonly X Sometimes ___Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 400

Is this service performed by many physicians across the United States? ___Yes X No

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Pediatric Cardiac Catheterization - Tab A

Recognizing that more of these procedures are being performed on children, new CPT codes were added for pediatric cardiac catheterization. These catheterizations are performed on patients to correct congenital anomalies. The specialty society reported that these procedures are considerably more complex, have a higher risk and require more time and expertise than similar procedures in patients with acquired heart disease. Because of the complexity of the procedure, the pre-procedure time is increased, with more time being spent in reviewing the non-invasive data and previous cardiac catheterizations. Since the vessels are smaller vascular access is more difficult in small children. In addition, the technical skill during the catheterization is increased in congenital anomalies, since the complex disease often reorients the heart, heart valves, and the ventricular septum and other structures may be in an abnormal position and location. It was also noted that children are more likely to develop complications and must be monitored more closely.

The RUC recommended an RVU of 4.23 for CPT code 93530, *Right heart catheterization, for congenital cardiac anomalies* which was lower than the specialty society recommendation but a higher RVU than the adult right heart catheterization code 93501 which has an RVU of 3.02.

Based on a survey of approximately 40 pediatricians and cardiologists, the RUC recommended an RVU of 8.35 for code 93531, *Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies* and 10.00 for code 93532, *Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies*. Both of these RVUs represent the survey medians.

The RUC recommended an RVU of 6.70 for CPT code 93533, *Right heart catheterization, for congenital cardiac anomalies* which was lower than the specialty society recommendation but the same as the RVU for the adult procedure code 93529 which has an RVU of 6.50.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•93530	AJ1	Right heart catheterization, for congenital cardiac anomalies	000	4.23
•93531	AJ2	Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies	000	8.35
•93532	AJ3	Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies	000	10.00
•93533	AJ4	Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, congenital cardiac anomalies	000	6.70

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

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

CPT Code: 9XXX1 Tracking Number: AJ-1 Global Period: 000 Recommended RVW: 6.0

CPT Descriptor: Right Heart Catheterization; Congenital Cardiac Anomalies

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 9-month old infant was noted to have a heart murmur soon after birth. A 2D echocardiogram and Doppler study demonstrated a large ventricular septal defect. Over the next few months he developed congestive heart failure but responded to Digoxin, diuretics, an increased caloric density of his formula. His weight gain has been slow, but consistently along the 5th percentile. This cardiac catheterization is being performed to measure the magnitude of the left-to-right shunt and to measure the pulmonary artery pressure and resistance to see if reparative surgery is indicated to prevent pulmonary vascular obstructive disease.

Description of Pre-Service Work: Pre-procedure physician work includes review of noninvasive work-up including echocardiogram, description of the test and expected results to the parents of the patient, a description of potential hazards and signature of informed consent for the procedure. Additional brief pre-service functions are: to acquaint the patient or parents with the catheterization laboratory, to supervise adequate sedation and comfort, to review laboratory arrangements and procedures with technicians.

Description of Intra-Service Work: The majority of catheter introductions are done percutaneously either into the internal jugular, subclavian, brachial or femoral venous systems under local anesthesia. Frequently, multiple attempts must be made because of very small vessels and/or venous thrombosis from previous studies. Typically, a venous sheath is placed in a large peripheral vein and the catheter passed through this sheath under fluoroscopic guidance. The catheter is then directed from the venous system into the superior vena cava, right atrium, right ventricle, right and left pulmonary arteries, and pulmonary capillary wedge position. Baseline measurements and blood sampling may be conducted in each of these chambers. Cardiac output is measured using thermodilution or using measured oxygen consumption via Fick method if intracardiac shunting is suspected. Positioning for angiography may occur in any of the right heart chambers, usually after exchanging a catheter used for physiologic data for an angiographic catheter.

Following measurement of baseline values, pharmacological intervention may be performed and the measurements repeated. Supplementary sedation is frequently necessary, especially in younger children.

Following the conduct of the catheterization proper, the catheter is extracted and compression hemostasis achieved, usually by the physician.

Description of Post-Service Work: Following catheterization, a report which includes interpretation of the hemodynamic information and response to intervention is generated, with pulmonary and systemic blood flow, left-to-right and right-to-left shunts and pulmonary vascular resistances are generated. After the patient has left the catheterization laboratory, there usually is at least one physician visit to ascertain clinical stability and satisfactory hemostasis.

Typical patients who undergo isolated right heart catheterization are those with simple congenital heart lesions being evaluated pre-operatively or post-operative patients where significant residual defects may be diagnosed and quantified from a single right heart catheterization. Examples would be patients with atrial septal and ventricular septal defects and post-operative tetralogy of Fallot, patients with primary pulmonary hypertension for measurement of pulmonary pressure and resistance to characterize the disease and monitor the prognosis, and patients with end stage congenital heart disease who are being evaluated for cardiac transplantation.

SURVEY DATA:Specialty: American Academy of Pediatrics & American College of CardiologySample Size: 200 Response Rate (%): 20% Median RVW: 5.99525th Percentile RVW: 4.1 75th Percentile RVW: 6.04050 Low: 3.1 High: 19.2Median Pre-Service Time: 47.5 Median Intra-Service Time: 9525th Percentile Intra-Svc Time: 70 75th Percentile Intra-Svc Time: 120 Low: 30 High: 210Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 52.5ICU: 0Other Hospital: 15Office: 15**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	93501	Rt. heart catheterization	3.02
2)	93526	Rt. & Lt. heart catheters	5.99
3)	93529	Rt., lt heart catheterization	4.80
4)	93527	Rt. & lt heart catheters	7.28

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
93501	35	60	45	2	2	2
93526	40	60	40	3	3	2.5

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? 93501

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1,000

Is this service performed by many physicians across the United States? ☐ Yes ☒ No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 9XXX2 Tracking Number: AJ-2 Global Period: 000 Recommended RVW: 8.35

CPT Descriptor: Combined Right Heart Catheterization and Retrograde Left Heart Catheterization; Congenital Cardiac Anomalies

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A typical patient would be a 4-year-old with tricuspid atresia with a secundum atrial septal defect, a ventricular septal defect, pulmonary stenosis with a hypoplastic right ventricle, who underwent an aorto pulmonary shunt in the newborn period. This child has been followed clinically with enough pulmonary blood flow so that he is not too dissaturated and yet not so much that he is in congestive heart failure. Because of the gradual spontaneous closure of his ventricular septal defect, his pulmonary blood flow is becoming less and he needs cardiac catheterization and angiography to evaluate the size of the left-to-right shunt, the pulmonary artery pressure and resistance, the location and severity of the pulmonary stenosis and an evaluation of the distal pulmonary artery tree to determine if a superior vena cava to pulmonary artery anastomosis (Glenn) or a total right heart bypass (Fontan) is the next appropriate step.

Description of Pre-Service Work: The pre-procedure physician's work involves a review of the history from the parents, a physical examination, and a review of the noninvasive tests including electrocardiogram, chest x-ray, and 2D echocardiogram and Doppler study. The latter is frequently personally reviewed because the distortion of the anatomy from congenital heart disease may make the course of the catheters unusual. The previous cardiac catheterization data is reviewed to determine the best site of vascular access and angiograms are reviewed for a detailed description of the previous anatomy. The family is frequently acquainted with the catheterization laboratory and the case reviewed with technicians and frequently anesthesiologists.

Description of Intra-Service Work: A venous catheterization is performed similar to that described for 9XXX1. Additionally, an arterial catheter is inserted into the brachial, axillary or femoral artery. Frequently multiple attempts will be necessary because of the reduced size of the artery in children and thrombosis from previous catheterization. A separate local anesthetic is frequently required since the artery may not be near the vein used for venous access. The catheter is directed from the arterial system into the ascending aorta and left ventricle, frequently across stenosis in the vessels or valve. Occasionally, the catheter must be passed across an Aorto pulmonary shunt (Blalock-Taussig) to gain access to the pulmonary artery. With catheters in both arterial and venous systems, the physiologic measurements including blood sampling for oxygen saturation and pressure recordings in pulmonary wedge, pulmonary artery, right ventricle, right atrium and superior vena cava from the venous side and left ventricle ascending aorta and descending aorta from the arterial side are obtained in close proximity, for measurement of left-to-right and right-to-left shunts, cardiac output, gradient across valves and valve area. Positioning for angiography is performed sometimes involving several injections and different angles. For many patients, if baseline values are abnormal (for example, showing increased pulmonary vascular resistance), pharmacologic intervention and oxygen, nitric oxide, Isuprel, or Dopamine may be performed with measurements repeated with each of the pharmacologic interventions.

Following the conduct of the catheterization the catheter is extracted and compression hemostasis achieved either conducted or supervised by the physician.

Description of Post-Service Work: A catheterization report which includes interpretation of the hemodynamic information and response to intervention is generated and pulmonary and systemic flows, left-to-right and right-to-left shunts and pulmonary and systemic vascular resistances at baseline and with interventions are calculated. After the patient has left the catheterization, a physician sees the patient on the floor to be certain there is clinical stability and satisfactory hemostasis. The results are then conveyed to the family.

Typically children and young adults who undergo right heart catheterization and retrograde left heart catheterization are those with moderately complex or complex heart disease, in whom the foramen ovale has sealed. Examples would be tetralogy of Fallot, tricuspid atresia, complex congenital heart disease like single ventricle after Aorto pulmonary shunts or pulmonary artery band, or for postoperative evaluation of complex surgical procedures, like Fontan-repair of single ventricle, arterial switch repair of double outlet right ventricle and to evaluate conduit obstruction after Restelli repair of transposition of the great arteries with the ventricular septal defect and pulmonary stenosis or atresia.

SURVEY DATA:Specialty: American Academy of Pediatrics & American College of CardiologySample Size: 200 Response Rate (%): 20% Median RVW: 8.355025th Percentile RVW: 7.2075 75th Percentile RVW: 11.7500 Low: 5.99 High: 28Median Pre-Service Time: 60 Median Intra-Service Time: 1525th Percentile Intra-Svc Time: 120 75th Percentile Intra-Svc Time: 180 Low: 64 High: 270Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 60 ICU: 0 0Other Hospital: 20 1Office: 30 1**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	93526	Rt & Lt heart catheters	5.99
2)	93527	Rt & Lt heart catheters	7.28
3)	93529	Rt, Lt heart catheterization	4.80
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
93526	45	60	45	3	3	3
93527	60	150	45	4	4	4

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? 93526

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 9,000

Is this service performed by many physicians across the United States? ☐ Yes ☒ No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 9XXX3 Tracking Number: AJ-3 Global Period: 000 Recommended RVW: 10.0

CPT Descriptor: Combined Right Heart Catheterization and Trans Septal Left Heart Catheterization Through Intact Septum with or Without Retrograde Left Heart Catheterization; Congenital Cardiac Anomalies

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A ten year old child born with multiple left sided obstructive lesions (Shone's syndrome) including mitral stenosis, coarctation of the aorta, a bicuspid aortic valve, and a ventricular septal defect presented in shock at 8 days of age. After the resuscitation he underwent repair of his coarctation of the aorta. At 2 years of age, because of pulmonary edema, he underwent resection of a supra valvar mitral ring and closure of a membranous ventricular septal defect. Because of a recurrence of congestive heart failure and failure to thrive with suggestive evidence of pulmonary artery hypertension, he underwent this cardiac catheterization to evaluate the success of repair of ventricular septal defect, and severity of residual mitral stenosis and coarctation. At catheterization he was found to have a moderate residual ventricular septal defect, pulmonary artery hypertension that responded to oxygen and nitric oxide, and biventricular dysfunction. There was only a small gradient across the mitral valve. Surgery was later performed to close the ventricular septal defect.

Description of Pre-Service Work: This procedure is very similar to 9XXX2 with the exception that the atrial septum is intact so that access to the left atrium to evaluate mitral stenosis in only by transatrial puncture.

Description of Intra-Service Work: After completing the right heart catheterization, the catheter is removed and replaced with a venous sheath that is placed in the right atrium against the wall of the left atrium. A long needle is placed through the sheath against the atrial septum and advanced sharply, puncturing the septum. After confirmation of position within the left atrium, the sheath is advanced through the hole and the needle replaced with a physiologic and later an angiographic catheter.

Description of Post-Service Work: After the catheterization is completed, the interpretation of the data and total post-procedure time are similar to code 9XXX2.

The typical person who would need this procedure would be someone with complex cyanotic heart disease, with mitral stenosis or atresia, for access to the left ventricle in a child a prosthetic aortic valve in whom retrograde left heart catheterization can not be performed, for tetralogy of Fallot with pulmonary atresia, for pulmonary venous wedge angiography to outline the hypoplastic pulmonary arteries, or for the child with severe aortic stenosis where the valve cannot be crossed in a retrograde fashion.

SURVEY DATA:

Specialty: American Academy of Pediatrics & American College of Cardiology

Sample Size: 200 Response Rate (%): 19 % Median RVW: 10

25th Percentile RVW: 9.5 75th Percentile RVW: 12 Low: 7.28 High: 40

Median Pre-Service Time: 60 Median Intra-Service Time: 175

25th Percentile Intra-Svc Time: 125 75th Percentile Intra-Svc Time: 180 Low: 90 High: 300

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
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Day of Procedure:	<u>60</u>	<u> </u>
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ICU:	<u>5</u>	<u>1</u>
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Other Hospital:	<u>20</u>	<u>1.5</u>
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Office:	<u>35</u>	<u>1</u>
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KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	93527	Rt & Lt heart catheters	7.28
2)	93526	Rt & Lt heart catheters	5.99
3)	92990	Revision of pulmmary valve	16.22
4)	99244	Office consultation	2.58

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
93527	45	120	60	4	4	4
93526	60	97.5	45	3	3.5	3.5

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? 93527

How often do physicians in your specialty perform this service? ___ Commonly x Sometimes ___ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1,000

Is this service performed by many physicians across the United States? ___ Yes x No

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 9XXX4 Tracking Number: AJ-4 Global Period: 000 Recommended RVW: 7.5

CPT Descriptor: Combined Right Heart Catheterization and Left Heart Catheterization Through Existing Septal Opening, with or Without Retrograde Left Heart Catheterization; Congenital Cardiac Anomalies

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A child who might undergo this procedure would be a 2 year old child with tetralogy of Fallot with increasing cyanosis, (hypoxemia) possibly even having a hypercyanotic spell. Surgery is necessary but noninvasive techniques including 2D echocardiography and Doppler flow studies are inadequate to obtain information needed by the surgeons, including the severity and distribution of right sided obstructive lesions (valvar, sub valvar and peripheral pulmonary stenosis), the number and location of ventricular septal defect(s), and to be certain that an anomalous coronary artery does not cross the right ventricular outflow tract in a region where the surgeon would normally place his outflow tract patch.

Description of Pre-Service Work: The pre-procedure physician work is similar to code 9XXX1 or 9XXX2.

Description of Intra-Service Work: After passing the catheter through the right heart chambers, its is withdrawn to the right atrium, passed posterior into the left atrium and pulmonary veins, and then anterior through the mitral valve into the left ventricle. Occasionally, the catheter is then passed into the aorta. Pressures are measured at each location and blood samples obtained for oxygen level and shunt calculations. The catheter is frequently exchanged for an angiographic catheter and, after positioning the child, one or more angiograms obtained in the different chambers.

Description of Post-Service Work: This code would be used for patients similar to those in code 9XXX2 in whom an atrial defect allows access to the left heart without a retrograde arterial study. An arterial puncture is usually done for arterial pressure monitoring.

This code is typically used for pre-op evaluation of congenital heart disease like tetralogy of Fallot, tricuspid atresia or transposition of the great arteries, or after palliation of surgical procedures of complex congenital heart disease including aorto pulmonary shunts, or pulmonary artery bands, or postoperative evaluation of complex surgical procedures like the Fontan repair of single ventricle, arterial switch for repair of double outlet right ventricle, and to evaluate conduit obstruction after repair of transposition of the great arteries with ventricular septal defect and pulmonary stenosis. This procedure is usually used in place of 9XXX2 when a patent foramen ovale allows access to the left side of the heart through the atrial septum.

SURVEY DATA:

Specialty: American Academy of Pediatrics & American College of Cardiology

Sample Size: 200 Response Rate (%): 21% Median RVW: 8.10

25th Percentile RVW: 6.85 75th Percentile RVW: 10.3 Low: 5.3 High: 25.8

Median Pre-Service Time: 60 Median Intra-Service Time: 120

25th Percentile Intra-Svc Time: 100 75th Percentile Intra-Svc Time: 151.5 Low: 70 High: 260

Median Post-Service Time:	<u>Total Time</u>	<u>Number of Visits</u>
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Day of Procedure:	<u>60</u>	<u> </u>
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ICU:	<u>30</u>	<u>1</u>
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Other Hospital:	<u>30</u>	<u>1</u>
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Office:	<u>30</u>	<u>1</u>
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KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1).	93529	Rt. & Lt Cath Thr/Septal Opening	4.8
2).	93526	Rt. & Lt Heart Catheterization	5.99
3).	93527	Rt. & Lt Heart Cath. Transseptal	7.28
4).	32100	Thoracotomy, major; with exploration & biopsy	10.07

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
93529	45	80	55	3	3	2
93526	45	80	45	3	3	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? 93529

How often do physicians in your specialty perform this service? X Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 9,000

Is this service performed by many physicians across the United States? Yes X No

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

PET Myocardial Perfusion Imaging - Tab B

The RUC considered revised RVU recommendations on PET imaging. The specialty society noted that the work described by codes 78491, *Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress*, and 78492, *Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and or stress* involve PET imaging of the heart and the procedures are similar in nature to PET for myocardial evaluation, CPT code 78459 (RVU = 1.88). The presenters also noted that at the February RUC meeting, many of the members of the RUC compared PET myocardial perfusion imaging codes to CPT code 78465, *Myocardial perfusion imaging; SPECT and multiple studies*. PET myocardial perfusion imaging involves more physician than 78465. Unlike the large field of view of SPECT scanners, PET scanners have a much smaller field. In addition, due to the short half-life of the Rb-82 tracer, physician involvement in patient positioning is critical, otherwise the target may be missed. To ensure the patient is properly positioned, a test dose is given by the physician. Therefore, more physician work both pre- and intra-service work is required than for the SPECT codes.

CPT code 78459 provided the benchmark for valuing the multiple study 78492 and the specialty societies felt that codes 78492 and 78491 should have the same proportionality (0.37) that exists between the single and the multiple SPECT studies (codes 78464 and 78465). The specialty societies recommended that code 78491 have an RVU of 1.50, which is valued 20% less than code 78459 (RVU = 1.88). Using the RVU margin of (0.37) representing the incremental difference in work between the single and multiple studies.

The RUC accepted the recommendation of 1.50 RVUs for 78491 and 1.87 RVUs for 78492 ($1.87 - 1.50 = 0.37$).

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•78491	Q1	Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress	XXX	1.50
•78492	Q2	multiple studies at rest and/or stress	XXX	1.87

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 784X1 Tracking Number: (Q1) Global Period: XXX Recommended RVW: 1.70

CPT Descriptor:

Myocardial imaging, positron emission tomography (PET) perfusion; single study at rest or stress

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 54 year old male, athletic, college president with known history of coronary heart disease had recurrent chest pain four months following an LAD angioplasty and stent.

Description of Pre-Service Physician Work:

- Review history and physical exam.
- Review EKG, chest x-ray, stress, and myocardial imaging data, ultrasound and angiographic data, if available.
- Interview patient.
- Discuss patient positioning and pre-procedure protocol (hydration, imaging time post-injection, etc.).

Description of Intra-Service Physician Work:

- Inject Rb-82 (or N-13) at rest.
- Determine adequacy of study and patient positioning [Do images need repeating because of poor quality (e.g. motion)?].
- Interpret PET data and correlate to previous cardiac information and clinical history.

Description of Post-Service Physician Work:

- Discuss results with patient.
- Dictate, correct, and sign report.
- Discuss and communicate report/findings with referring physician(s).

SURVEY DATA:

Specialty: American College of Cardiology

Sample Size: 21 Response Rate (%): 35% Median RVW: 1.6

25th Percentile RVW: 1.47 75th Percentile RVW: 1.895 Low: 1.1 High: 3.0

SURVEY DATA:

Specialty: American College of Radiology

Sample Size: 119 Response Rate (%): 17/119, 14% Median RVW: 1.75

25th Percentile RVW: 1.6 75th Percentile RVW: 1.88 Low: 1.2 High: 2.2

SURVEY DATA:

Specialty: Society of Nuclear Medicine/American College of Nuclear Physicians

Sample Size: 38 Response Rate (%): 25/38, 65.8% Median RVW: 1.75

25th Percentile RVW: 1.56 75th Percentile RVW: 1.85 Low: 1.1 High: 2.35

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Organization</u>
1)	78465	Myocardial perfusion imaging; tomographic (SPECT), multiple studies, at and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, qualitative or quantitative	1.46	ACC, ACR, SNM
2)	78459	Myocardial perfusion imaging, PET, metabolic evaluation	1.88 (RUC)	ACC, ACR, SNM

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

Compare the total physician time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Total Physician Time (ACC)	Median Mental Effort Judgement (ACC)	Median Technical Skill & Physical Effort (ACC)	Median Psychological Stress (ACC)
784X1	55	4	4	3.5
78465	42.5	4	3	4
78459	70	5	3	4

ACC

CPT Code	Median Total Physician Time (ACR)	Median Mental Effort Judgement (ACR)	Median Technical Skill & Physical Effort (ACR)	Median Psychological Stress (ACR)
784X1	35	4	4	4
78465	30	4	4	4
78459	35	4	4	4

ACR

CPT Code	Median Total Physician Time (SNM)	Median Mental Effort Judgement (SNM)	Median Technical Skill & Physical Effort (SNM)	Median Psychological Stress (SNM)
784X1	45	4	4	4
78465	45	4	4	4
78459	60	5	4	4

SNM/ACNP

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

The recommended RVW is based on the weighted average of each organization's median RVW.

FREQUENCY INFORMATION

How was this service previously reported?

HCPC II codes (G series G0030 - G0047) to cover Rb-82 myocardial perfusion imaging.

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 10,000

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

CPT Code: 784X1

Indicate the number of times that you have performed these services over the past year.

ACC: CPT Code 784X1 50 (Median)

ACR: CPT Code 784X1 20 (Median)

SNM: CPT Code 784X1 18 (Median)

Does the typical patient/service listed on Page 3, describe your typical patient?

ACC: Yes (43%) No (33%)

ACR: Yes (75%) No (25%)

SNM: Yes 15/17 (88.2%) No 2/17 (11.8%)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 784X2 Tracking Number: (Q2) Global Period: XXX Recommended RVW: 1.94

CPT Descriptor:

Myocardial imaging, positron emission tomography (PET) perfusion; multiple studies at rest and/or stress

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 53 year old female, obese widow with three children at home, who has a family history of coronary heart disease and a person history of elevated cholesterol and hypertension, is referred for evaluation of recent onset of atypical chest pain and LBBB.

Description of Pre-Service Physician Work:

- Review history and physical exam.
- Review EKG, chest x-ray, stress, and myocardial imaging data, ultrasound, and angiographic data, if available.
- Interview patient.
- Discuss patient positioning and pre-procedure protocol (hydration, imaging time post-injection, etc.).

Description of Intra-Service Physician Work:

- Inject Rb-82 (or N-13) at rest and stress.
- Determine adequacy of studies and patient positioning [Do images need repeating because of poor quality (e.g. motion)?].
- Interpret PET data and correlate to previous cardiac information and clinical history.

Description of Post-Service Physician Work:

- Discuss results with patient.
- Dictate, correct, and sign report.
- Discuss and communicate report/findings with referring physician(s).

SURVEY DATA:

Specialty: American College of Cardiology

Sample Size: 21 Response Rate (%): 35% Median RVW: 1.95

25th Percentile RVW: 1.6 75th Percentile RVW: 2.09 Low: 1.5 High: 3.0

SURVEY DATA:

Specialty: American College of Radiology

Sample Size: 119 Response Rate (%): 16/119, 13% Median RVW: 1.9

25th Percentile RVW: 1.75 75th Percentile RVW: 2 Low: 1 High: 2.5

SURVEY DATA:

Specialty: Society of Nuclear Medicine/American College of Nuclear Physicians

Sample Size: 38 Response Rate (%): 25/38, 65.8% Median RVW: 1.95

25th Percentile RVW: 1.8 75th Percentile RVW: 2 Low: 1.46 High: 2.4

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Organization</u>
1)	78465	Myocardial perfusion imaging; tomographic (SPECT), multiple studies, at and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, qualitative or quantitative	1.46	ACC, ACR, SNM
2)	78459	Myocardial perfusion imaging, PET, metabolic evaluation	1.88 (RUC)	ACC, ACR, SNM

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

Compare the total physician time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Total Physician Time (ACC)	Median Mental Effort Judgement (ACC)	Median Technical Skill & Physical Effort (ACC)	Median Psychological Stress (ACC)
784X2	65	4	4	4
78465	50	4	3	3.5
78459	70	5	3	4

ACC

CPT Code	Median Total Physician Time (ACR)	Median Mental Effort Judgement (ACR)	Median Technical Skill & Physical Effort (ACR)	Median Psychological Stress (ACR)
784X2	45	4	4	4
78465	47.5	4	4	4
78459	35	5	5	4

ACR

CPT Code	Median Total Physician Time (SNM)	Median Mental Effort Judgement (SNM)	Median Technical Skill & Physical Effort (SNM)	Median Psychological Stress (SNM)
784X2	55	5	5	5
78465	45	4	4	5
78459	70	5	4.5	4

SNM/ACNP

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

The recommended RVW is based on the weighted average of each organization's median RVW.

FREQUENCY INFORMATION

How was this service previously reported?

HCPC II codes (G series G0030 - G0047) to cover Rb-82 myocardial perfusion imaging.

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 10,000

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

CPT Code: 784X2

Indicate the number of times that you have performed these services over the past year.

ACC: CPT Code 784X2 289 (Median)

ACR: CPT Code 784X2 25 (Median)

SNM: CPT Code 784X2 12 (Median)

Does the typical patient/service listed on Page 3, describe your typical patient?

ACC: Yes (52%) No (14%)

ACR: Yes (89%) No (11%)

SNM: Yes 14/17 (82.4%) No 3/17 (17.6%)

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Renal Nuclear Medicine - Tab C

The RUC considered revised RVU recommendations on Renal Nuclear Medicine. The presenters noted that they would like to clarify what constitutes physician work involved in the utilization of angiotensin and diuretics in renal studies. The specialty societies noted that the hydration component of procedures 78708, *Kidney imaging with vascular flow and function; single study, with pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic* and 78709, *Kidney imaging with vascular flow and function; multiple studies, with pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic* are very important as the physician is pharmacologically manipulating patients with diuretics. The physicians personally obtains and records blood pressure following the administration of an ACE inhibitor for renal hypertension studies.

CPT code 78707, *Kidney imaging with vascular flow and function; single study without pharmacological intervention* represents the basic kidney imaging and function study code. The specialty society recommended 0.96 RVUs for this procedure. The recommended RVU of 1.21 for CPT code 78708 represents the basic kidney function and imaging code plus the added work of pharmacologic intervention. The recommended RVU of 1.41 RVUs for CPT code 78709 reflects the fact that the kidney imaging study with flow and function is performed first without pharmacologic intervention and then repeated with the drugs several hours later. With regard to CPT code 78709 the RUC was concerned that the recommended RVU for this procedure was higher than the RVU of a multiple study planar myocardial perfusion imaging (code 78461, RVU = 1.23). The specialties clarified that the two study nature of code 78709 requires more physician work. All of the RVUs that the specialties recommended to the RUC were the same values that were presented at the February RUC meeting. The RUC felt that based on the clarifications that the specialty societies have made to their rationale since that time these recommendations were appropriate. The RUC accepted the specialty society recommendations.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
78707	R1	<u>Kidney imaging with vascular flow and function; single study without pharmacological intervention</u>	XXX	0.96
•78708	R2	single study, with pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)	XXX	1.21
•78709	R3	multiple studies, with and without pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)	XXX	1.41
78725	R4	Kidney function study without pharmacologic intervention	XXX	N/A
78726	R5	Kidney function study including pharmacologic intervention	XXX	N/A
78727	R6 .99	Kidney transplant evaluation (78727 has been deleted. To report, see 78700-78707)	XXX	N/A

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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 78707 Tracking Number: (R1) Global Period: XXX Recommended RVW: 0.96

CPT Descriptor:

Kidney imaging with vascular flow and function; single study without pharmacological intervention.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 24 year old woman who had a renal transplantation five days previously, is referred for her third post-operative radionuclide renal study because of decreasing urine output and rising creatinine.

A 78 year old man who has chronic left ventricular failure and recent development of atrial fibrillation is referred for a renal evaluation because of onset of rising creatinine and decreasing urine output.

Description of Pre-Service Physician Work:

- Review history and physical exam.
- Review previous diagnostic studies, if available.
- Interview patient.

Description of Intra-Service Physician Work:

- Obtain and interpret vascular flow, function and imaging data.

Description of Post-Service Physician Work:

- Discuss results with patient.
- Dictate, correct, and sign report.
- Discuss and communicate report/findings with referring physician(s).

SURVEY DATA:

Specialty: American College of Radiology

Sample Size: 119 Response Rate (%): 26/119, 22% Median RVW: 0.99

25th Percentile RVW: 0.95 75th Percentile RVW: 1 Low: 0.50 High: 1.48

SURVEY DATA:

Specialty: Society of Nuclear Medicine/American College of Nuclear Physicians

Sample Size: 38 Response Rate (%): 33/38, 86.8% Median RVW: 1

25th Percentile RVW: 0.96 75th Percentile RVW: 1.1 Low: 0.84 High: 1.8

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Organization</u>
1)	78707	Kidney imaging; with vascular flow and function study.	0.94	ACR & SNM
2)	78727	Renal transplant study	0.99	ACR & SNM
3)	78472	Cardiac blood pool imaging, gated equilibrium; single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing	0.98	SNM
4)	78223	Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function	0.84	ACR & SNM
5)	78278	Acute gastrointestinal blood loss imaging	0.99	SNM

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

Compare the total physician time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Total Physician Time		Median Mental Effort Judgement		Median Technical Skill & Physical Effort		Median Psychological Stress	
	(ACR)	(SNM)	(ACR)	(SNM)	(ACR)	(SNM)	(ACR)	(SNM)
78707 (R1)	20	20	3	3	3	3	3	3
78707	25	25	3	3	3	3	3	3
78727	25	27.5	3	3.5	N/A	3	N/A	3.5
78472		25		3		3		3
78223	15	17.5	3	3	3	3	3	3
78278		12.5		3		3		3

RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

Since the revised 78707 now includes renal transplant studies (78727), we feel that an increase in the work value is justified, however, both organizations agree that the weighted average of the two median RVWs, 1.00, is too high and have agreed upon a recommended RVW of .96.

FREQUENCY INFORMATION

How was this service previously reported?

For CPT 1998, the CPT codes for kidney function without or with pharmacologic intervention (78725 and 78726, respectively) will be deleted. The code for kidney transplant evaluation (78727) will also be deleted.

In their place, existing code 78707 describes a single kidney imaging study with flow and function. Revised code 78707 should also be used to evaluate kidney transplants. Code 78707 will be supplemented with two new codes: (1) for a single imaging study with flow and function, with pharmacologic intervention and (2) for multiple studies, without and with pharmacologic intervention. These new codes can be used to evaluate patients with hypertension and/or urinary obstructive disease.

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 100,000

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

CPT Code: 78707

Indicate the number of times that you have performed these services over the past year.

ACR: CPT Code 78707 100 (Median)

SNM: CPT Code 78707 117.5 (Median)

Does the typical patient/service listed on Page 3, describe your typical patient?

ACR: Yes (94.7%) No (5.3%)

SNM: Yes 24/29 (82.8%) No 5/29 (13.2%)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 787X1 Tracking Number: (R2) Global Period: XXX Recommended RVW: 1.21

CPT Descriptor:

Kidney imaging with vascular flow and function; single study, with pharmacological intervention (e.g., angiotensin converting enzyme inhibitor and/or diuretic.)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 43 year old woman with persistent hypertension that has not responded to treatment is referred for possible renovascular hypertension.

A 7 year old female with a history of surgically treated ureteral reflux and residual right-sided hydronephrosis, is referred for evaluation of renal urinary obstruction.

Description of Pre-Service Physician Work:

- Review history and physical exam.
- Review previous diagnostic studies, if available.
- Interview patient.
- Basal blood pressures are obtained.
- A slow drip of 0.5N saline is started via an intravenous line.
- In question of urinary of obstruction, assure urinary bladder catheterization.

Description of Intra-Service Physician Work:

- If the study is being performed for hypertension, obtain basal blood pressures.
- Administer ACE-inhibitor (oral or intravenous) and monitor patient's blood pressure for up to one hour.
- Obtain and interpret vascular flow, function and imaging data following administration of an ACE-inhibitor.
- In the presence of urinary obstruction, monitor kidney function during procedure and designate time of diuretic injection

Description of Post-Service Physician Work:

- Discuss results with patient.
- Dictate, correct, and sign report.
- Discuss and communicate report/findings with referring physician(s).

CPT Code: 787X1

SURVEY DATA:

Specialty: Amercian College of Radiology

Sample Size: 119 Response Rate (%): 27/119, 23% Median RVW: 1.15
 25th Percentile RVW: 1.05 75th Percentile RVW: 1.40 Low: 0.60 High: 4.48

SURVEY DATA:

Specialty: Society of Nuclear Medicine/American College of Nuclear Physicians

Sample Size: 38 Response Rate (%): 33/38, 86.8% Median RVW: 1.25
 25th Percentile RVW: 1.08 75th Percentile RVW: 1.5 Low: 0.94 High: 2

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Organization</u>
1)	78707	Kidney imaging; with vascular flow and function study.	0.94	ACR & SNM
2)	78465	Myocardial perfusion imaging; tomographic (SPECT), multiple studies, at and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, qualitative or quantitative	1.46	ACR & SNM
3)	78461	Myocardial perfusion imaging; multiple studies, at and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, qualitative or quantitative	1.23	SNM
4)	78585	Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath	1.09	ACR
5)	78727	Renal transplant study	0.99	ACR

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

Compare the total physician time and the intensity (mental effort and judgement; technical skill & physical effort, and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Total Physician Time		Median Mental Effort Judgement		Median Technical Skill & Physical Effort		Median Psychological Stress	
	(ACR)	(SNM)	(ACR)	(SNM)	(ACR)	(SNM)	(ACR)	(SNM)
787X1	30	35	4	4	4	4	3	4
78707	25	25	3	3	3	3	3	3
78461		35		4		4		4
78465	26.5	33	4	4	4	4	4	4

RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

The recommended RVW is based on the weighted average of each organization's median RVW.

FREQUENCY INFORMATION

How was this service previously reported?

For CPT 1998, the CPT codes for kidney function without or with pharmacologic intervention (78725 and 78726, respectively) will be deleted. The code for kidney transplant evaluation (78727) will also be deleted.

In their place, existing code 78707 describes a single kidney imaging study with flow and function. Revised code 78707 should also be used to evaluate kidney transplants. Code 78707 will be supplemented with two new codes: (1) for a single imaging study with flow and function, with pharmacologic intervention and (2) for multiple studies, without and with pharmacologic intervention. These new codes can be used to evaluate patients with hypertension and/or urinary obstructive disease.

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 30,000.

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

CPT Code: 787X1

Indicate the number of times that you have performed these services over the past year.

ACR: CPT Code 787X1 75 (Median)

SNM: CPT Code 787X1 95.5 (Median)

Does the typical patient/service listed on Page 3, describe your typical patient?

ACR: Yes (100%) No (0%)

SNM: Yes 25/26 (96%) No 1/26 (3.8%)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 787X2 Tracking Number: (R3) Global Period: XXX Recommended RVW: 1.41

CPT Descriptor:

Kidney imaging with vascular flow and function; multiple studies, with and without pharmacological intervention (e.g., angiotensin converting enzyme inhibitor and/or diuretic.)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 43 year old woman with recent onset of hypertension is referred for possible renovascular hypertension.

Description of Pre-Service Physician Work:

- Review history and physical exam.
- Review previous diagnostic studies, if available.
- Interview patient.
- Obtain basal blood pressures.

Description of Intra-Service Physician Work:

- Obtain and interpret vascular flow, function and imaging data.
(Several hours later:)
- Basal blood pressures are obtained.
- A slow drip of 0.5N saline is started via an intravenous line.
- Administer ACE-inhibitor (oral or intravenous) and monitor patient's blood pressure for up to one hour.
- Repeat renal imaging study and interpret vascular flow, function and imaging data, comparing results from both sets of studies.

Description of Post-Service Physician Work:

- Discuss results with patient.
- Dictate, correct, and sign report.
- Discuss and communicate report/findings with referring physician(s).

SURVEY DATA:CPT Code: 787X2Specialty: American College of RadiologySample Size: 119 Response Rate (%): 26/119, 22% Median RVW: 1.3525th Percentile RVW: 1.20 75th Percentile RVW: 1.50 Low: 0.69 High: 2.22**SURVEY DATA:**Specialty: Society of Nuclear Medicine/American College of Nuclear PhysiciansSample Size: 38 Response Rate (%): 31/38, 81.6% Median RVW: 1.4625th Percentile RVW: 1.275 75th Percentile RVW: 1.7 Low: 1.03 High: 2.75**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Organization</u>
1)	78465	Myocardial perfusion imaging; tomographic (SPECT), multiple studies, at and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, qualitative or quantitative	1.46	ACR & SNM
2)	78461	Myocardial perfusion imaging; multiple studies, at and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, qualitative or quantitative	1.23	SNM
3)	78707	Kidney imaging; with vascular flow and function study.	0.94	ACR & SNM
4)	78585	Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath	1.09	ACR
5)	78727	Renal transplant study	0.99	ACR

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

Compare the total physician time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Total Physician Time		Median Mental Effort Judgement		Median Technical Skill & Physical Effort		Median Psychological Stress	
	(ACR)	(SNM)	(ACR)	(SNM)	(ACR)	(SNM)	(ACR)	(SNM)
787X2	35	45	4	4	4	4	4	4
78707	25	40	3	4	3	4	3	4
78461		42.5		4		4		4
78465	20	22	4	3	4	3	4	3

RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

The recommended RVW is based on the weighted average of each organization's median RVW.

FREQUENCY INFORMATION

How was this service previously reported?

For CPT 1998, the CPT codes for kidney function without or with pharmacologic intervention (78725 and 78726, respectively) will be deleted. The code for kidney transplant evaluation (78727) will also be deleted.

In their place, existing code 78707 describes a single kidney imaging study with flow and function. Revised code 78707 should also be used to evaluate kidney transplants. Code 78707 will be supplemented with two new codes: (1) for a single imaging study with flow and function, with pharmacologic intervention and (2) for multiple studies, without and with pharmacologic intervention. These new codes can be used to evaluate patients with hypertension and/or urinary obstructive disease.

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 10,000

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

CPT Code: 787X2

Indicate the number of times that you have performed these services over the past year.

ACR: CPT Code 787X2 43 (Median)

SNM: CPT Code 787X2 67.5 (Median)

Does the typical patient/service listed on Page 3, describe your typical patient?

ACR: Yes 16/17 (94%) No 1/17 (6%)

SNM: Yes 20/22 (90.9%) No 2/22 (9.1%)

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Magnetic Resonance Spectroscopy - Tab D

The RUC considered revised RVU recommendations on Magnetic Resonance Spectroscopy. The specialty society noted that during the intra-service portion of the procedure, the physician must select the regions of study and interpret spectral images. It was also noted that the interpretation of these spectral images requires more physician work than the interpretation of the images that the study produces.

Based on their survey results, the specialty society recommended the 25th percentile value of their survey which is 1.40 for code 76390, *Magnetic resonance spectroscopy*. The RUC accepted this recommendation with the understanding that the CPT descriptor is changed so that this procedure is recognized as a stand-alone not an add-on procedure.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•76390	FF1	Magnetic resonance spectroscopy (For magnetic resonance imaging, use appropriate MRI body site code)	XXX	1.40

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION
American College of Radiology

CPT Code: 764XX Tracking Number: FF1 Global Period: XXX Recommended RVW: 1.65

CPT Descriptor: Magnetic Resonance Spectroscopy (use code 764XX in addition to code for magnetic resonance imaging)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A thirty-two year old male presented with left facial weakness. MRI showed a mass involving the left thalamus and obstructive hydrocephalus. MRS performed, which showed choline consistent with a neoplastic process probably of high grade.

Description of Pre-Service Work:

See Attachment

Description of Intra-Service Work:

See Attachment

Description of Post-Service Work:

See Attachment

SURVEY DATA:

Specialty: American College of Radiology

Sample Size: 67 Response Rate (%): 25% (N=17) Median RVW: 1.65

25th Percentile RVW: 1.40 75th Percentile RVW: 1.90 Lowest RVW: 0.45 Highest RVW: 4.0

Median Total Service Time: 28 minutes 25th Percentile Total Service Time: 20 minutes

75th Percentile Total Service Time: 40 minutes Lowest Total Time: 10 minutes

Highest Total Time: 135 minutes

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material	1.48
2)	72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents with contrast material	1.92

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

Compare the total-service time and the intensity (mental effort and judgment; technical skill and physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Total Time	Median Mental Effort & Judgment	Median Technical Skill & Physical Effort	Median Psychological Stress
764XX	28	4	3	3
70551	23	4	3	3
72142	20	4	3	3

Number of times performed in last 12 months (median)	12
Agree with vignette?	Yes (75%, N=9) No (25%, N=3)

ADDITIONAL RATIONALE

The recommended RVW is based on the survey median RVW.

FREQUENCY INFORMATION

How was this service previously reported? 76499

How often do physicians in your specialty perform this service?

Commonly X Sometimes _____ Rarely _____

Estimate the number of times this service might be performed nationally in a one-year period? Unable to quantify

Is this service performed by many physicians across the United States? Yes X No _____

Clinical Description of Service and Vignette

Code: 764XX Magnetic resonance spectroscopy

Note: This code is used in addition to the code for magnetic resonance imaging.

Clinical Vignette:

A thirty-two year old male presented with left facial weakness. MRI showed a mass involving the left thalamus and obstructive hydrocephalus. MRS performed, which showed choline consistent with a neoplastic process probably of high grade.

Description of Physician Work Associated With This Procedure:

Pre-Service Physician Work:

- Review history and physical exam.
- Review MRI imaging data to determine the best plane and pulse sequence for localizer images. (*The initial MRI scan is reported separately.*)

Intra-Service Physician Work:

- Obtain localizer images in axial and/or coronal plane(s).
- Identify abnormality or region of interest.
- Perform shimming, localization, and acquire data.
- Inspect spectrum/spectra and determine if additional regions of interest are needed.
- Calculate ratios of peaks. Compare with normal spectra and abnormal patterns for definitive evaluation of lesion.

Post-Service Physician Work:

- Discuss results with patient
- Dictate, correct, and sign report
- Discuss and communicate report/findings with referring physician(s)

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Trichogram - Tab E

The RUC considered revised RVU recommendations on Trichogram. The specialty society noted that the trichogram procedure includes three components; 1) the physician selecting and obtaining the specimen; 2) preparation of the slide; and 3) interpretation of the slide.

The RUC affirmed the specialty society's contention that this procedure is not part of the Evaluation and Management of portion of a patient visit to evaluate hair loss. Trichogram constitutes a separate service consisting of three components described above. The comparable codes are blood smear (85060, RVUs =0.45) and crystal identification by light (89060-26, RVUs =0.37). The RUC also noted that this procedure was comparable to the low level office visit (99201, RVUs =0.45). The RUC recommends the survey 25th percentile of 0.41.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•96902	S1	Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality	XXX	0.41

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 969XX Tracking Number: S1 Global Period: XXX Recommended RVW: 0.70RVW

CPT Descriptor: Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts or structural hair shaft abnormality.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 26 year old woman, four months post-partum, presents for diffuse hair loss. Past medical history is not significant for thyroid disease, anemia, hormonal disorders, or taking any medications causing specific hair loss. As noted per medical record review, the examination does not disclose any noticeable hair loss, but the patient insists that her hair is much thinner than one year previously. A trichogram is performed and shows nine of 22 hairs to be in telogen phase. Final diagnosis: telogen effluvium, consistent with post-partum effluvium and the patient is reassured that spontaneous regrowth is expected without specific treatment. Thirty of 33 said the vignette describes the typical patient.

Description of Pre-Service Work:

- Review with the patient the trichogram procedure and modalities/treatments for hair loss.
- Decision on necessity for concurrent laboratory evaluation.
- Preparation of instrument, including addition of rubber, vinyl or plastic tubing to the functional tips of a Kelly clamp or hemostat.
- Obtain informed consent.

Description of Intra-Service Work: Locate suitable area for pulling or clipping hair.

For trichogram:

- Grasp and clamp approximately 20 hairs within 1cm of the scalp. Rotate the clamp one-quarter turn clockwise, then pull abruptly and firmly perpendicular to the scalp line.
- Remove hairs from the clamp and float proximal ends in a small water bath or stabilize between glass microscope slides.
- Examine the hair roots using 10x magnification or a dissecting microscope, counting all hairs in telogen phase, anagen phase, and indeterminate hairs.

For hair clippings:

- Cut several centimeter length of hair near the proximal end of the hair shaft.
- Examination using 10x magnification for evidence of trichorrhexis, pili torti, or other hair shaft abnormality. Polarization filters may be used to examine for birefringence, as may be seen in trichothiodystrophy.

Description of Post-Service Work:

- Discussion with the patient of findings of the hair analysis and treatment planned.
- Completion of medical record charting, including documentation of the total number of hairs examined as well as the number of hairs in each growth stage. For microscopic hair analysis and/or polarization microscopy, documentation of the hair shaft and any abnormalities.

SURVEY DATA:

Specialty: American Academy of Dermatology (AAD), American Society for Dermatologic Surgery (ASDS) and Society for Investigative Dermatology (SID)

Sample Size: 133 Response Rate (%): 25% (#33) Median RVW: 0.70

25th Percentile RVW: 0.40 75th Percentile RVW: 0.78 Low: 0.03 High: 2.28

Median Pre-Service Time: 5 Median Intra-Service Time: 8

25th Percentile Intra-Svc Time: 4 75th Percentile Intra-Svc Time: 10 Low: 1 High: 15

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Global Period</u>
1)	88304-26	Tissue Exam by Pathologist	0.22	XXX
2)	88305-26	Tissue Exam by Pathologist	0.75	XXX
3)	11100	Biopsy of Skin Lesion	0.81	000
4)	99202	Office/Outpatient Visit, New	0.75	XXX

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

AMA/RUC staff searched the database and were unable to find Harvard pre-, intra- and post-service times for the selected reference services.

The committee believes that the work is comparable to CPT 88305-26 which is the dermatopathology code for the physician's analysis of the slide that is prepared and billable separately (88305-TC). The trichogram code, 969XX includes three components: the physician selection of the specimen, preparation of slide and interpretation of the slide.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental effort Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
969XX	5	8	0	3	4	2
88304-26	3	5	2	3	2	2
88305-26	2	5	1	4	3	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

NOT APPLICABLE

FREQUENCY INFORMATION

How was this service previously reported? It was not reported

How often do physicians in your specialty perform this service? X Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1,000+

How many physicians across the United States? X Yes No



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June 4, 1997

James G. Hoehn, M.D.

Chair, RVS Update Committee
American Medical Association
Department of Payment Systems
515 N. State Street
Chicago, IL 60610

Re: RVW Recommendation for New CPT 95870

Dr. Hoehn:

The American Academy of Neurology, American Association of Electrodiagnostic Medicine, and the American Academy of Physical Medicine and Rehabilitation recommend that a physician work relative value of 0.37 be assigned to new code CPT 95870 - Needle electromyography; other than paraspinal (eg, abdomen, thorax). An RVW of 0.37 represents the value of the current code CPT 95869 - Needle electromyography; limited study of specific muscles (eg, thoracic spinal muscles).

The CPT Editorial Panel recently decided, without the request of any medical society, to change the descriptor for CPT 95869 so it refers to needle EMGs performed specifically on thoracic paraspinal muscles. The Editorial Panel then created CPT 95870 to be used for needle EMGs performed on muscles other than paraspinal (these tests are currently billed under CPT 95869). The physician work for the services as described by these two codes is exactly the same and as such, the RVW should be identical. The societies listed above believe there is no reason to survey CPT 95870.

Should the RUC have any additional questions regarding this recommendation, we would be happy to answer them at the time of the September meeting.

Sincerely,

Neil Busis, M.D.

RUC Advisory Committee Member

American Academy of Neurology and American Association of Electrodiagnostic Medicine

cc. Marc Nuwer, MD (AAN), Bruce Sigbee, MD (AAN), John Nicholas, MD (AAPM&R), Sherry Smith (AMA), Lori Hattenhauer (AAEM), Melanie Claussen, (AAPM&R)



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**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
RBRVS FIVE-YEAR REVIEW**

REMAINING ISSUES REFERRED TO THE CPT EDITORIAL PANEL

The RUC reviewed several issues from the Five-Year Review of the RBRVS which were referred to the CPT Editorial Panel and which no action has yet been taken. The RUC received responses from several specialty societies indicating that they have submitted or are developing coding proposals for each of these codes for CPT 1999. The current work RVU for each of these services should be maintained in 1998.

CPT Code	Descriptor	95 RVU	97 RVU	COMMENTER	COMMENT	RUC Rationale	Status of Code Proposal or RVW Recommendation
11971	Removal of tissue expander(s) without insertion of prosthesis	1.51	1.51	CMD	A CMD commented that this code is roughly two times the difference in intra-service work of 11970 <i>Replacement of tissue expander with permanent prosthesis</i> (6.65), plus follow-up visits in the global period and recommended an RVU of 3.60.	The CPT code needs to be clarified. A number of different specialties are using the code, some inappropriately. The Editorial Panel needs to address the how the repair should be reported.	CPT will review add-on codes during the <u>CPT 1999</u> coding cycle. Current Work RVU should be maintained for 1998.
13300	Repair, unusual, complicated, over 7.5 cm, any area	5.11	5.11	ASPRS/IND	An individual commented that Code 13300 is undervalued and raised concern regarding potential abuse of this code. ASPRS also commented that these codes are extremely variable and indistinct.	CPT should clarify these codes to minimize potential abuse.	CPT will review add-on codes during the <u>CPT 1999</u> coding cycle. Current Work RVU should be maintained for 1998.
14300	Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area	10.76	10.76	ASPRS			CPT will review add-on codes during the <u>CPT 1999</u> coding cycle. Current Work RVU should be maintained for 1998.
15000	Excisional preparation or creation of recipient site by	1.95	1.95	ASPRS	ASPRS expressed concern that many varying sizes of	All these codes are highly variable in time, intensity,	CPT will review add-on codes during the <u>CPT 1999</u>

CPT Code	Descriptor	95 RVU	97 RVU	COMMENTER	COMMENT	RUC Rationale	Status of Code Proposal or RVW Recommendation
	excision of essentially intact skin (including subcutaneous tissue), scar, or other lesion prior to repair with free skin graft (list as separate service in addition to skin graft)				wounds fall under this one code and that the preparation of this is externally inconsistent.	work and morbidity. These codes are used in conjunction with other codes. The ASPRS requested, and the RUC agrees, that CPT review the issue of add-on codes.	coding cycle. Current Work RVU should be maintained for 1998.
15101	Split graft, trunk, scalp, arms, legs, hands, and/or feet (except multiple digits); each additional 100 sq cm, or each one percent of body area of infants and children, or part thereof	1.72	1.72	ASPRS	The ASPRS commented that these "add on" codes, for each additional 100 sq cm of split graft or 20 sq cm of full thickness graft, were undervalued in terms of time and intensity and recommended that they should be increased to reflect one third of the RVU of the primary procedure.	All these codes are highly variable in time, intensity, work and morbidity. These codes are used in conjunction with other codes. The ASPRS requested, and the RUC agrees, that CPT review the issue of add-on codes.	CPT will review add-on codes during the <u>CPT 1999</u> coding cycle. Current Work RVU should be maintained for 1998.
15121	Split graft, face, eyelids, mouth, neck, ears, orbits, genitalia, and/or multiple digits; each additional 100 sq cm, or each one percent of body area of infants and children, or part thereof	2.67	2.67	ASPRS			CPT will review add-on codes during the <u>CPT 1999</u> coding cycle. Current Work RVU should be maintained for 1998.
15201	Full thickness graft, free, including direct closure of donor site, trunk; each additional 20 sq cm	1.32	1.32	ASPRS	The ASPRS commented that these "add on" codes, for each additional 100 sq cm of split graft or 20 sq cm of full thickness graft, were undervalued in terms of time and intensity and recommended that they should be increased to reflect one third of the RVU of the primary procedure.	All these codes are highly variable in time, intensity, work and morbidity. These codes are used in conjunction with other codes. The ASPRS requested, and the RUC agrees, that CPT review the issue of add-on codes.	CPT will review add-on codes during the <u>CPT 1999</u> coding cycle. Current Work RVU should be maintained for 1998.

CPT Code	Descriptor	95 RVU	97 RVU	COMMENTER	COMMENT	RUC Rationale	Status of Code Proposal or RVW Recommendation
15221	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm	1.19	1.19	ASPRS	SEE ABOVE	SEE ABOVE	CPT will review add-on codes during the <u>CPT 1999</u> coding cycle. Current Work RVU should be maintained for 1998.
15241	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; each additional 20 sq cm	1.86	1.86	ASPRS			CPT will review add-on codes during the <u>CPT 1999</u> coding cycle. Current Work RVU should be maintained for 1998.
15261	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; each additional 20 sq cm	2.23	2.23	ASPRS			CPT will review add-on codes during the <u>CPT 1999</u> coding cycle. Current Work RVU should be maintained for 1998.
31090	Sinusotomy combined, three or more sinuses	8.65	8.65	AAO-HNS	This service involves an open procedure to remove disease in three or more sinuses and is similar to codes 31075 <i>Sinusotomy frontal; transorbital, unilateral (for mucocoele or osteoma, Lynch type)</i> (work RVU = 8.57) and 31255 <i>Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)</i> (work RVU = 6.96) combined. It appears that code 31090 has been confused with the endoscopic procedures.	This code should be clarified with a change in the CPT descriptor. The code should reflect that the service is an open procedure, unilateral, and specify the three sinuses.	Coding proposal submitted to editorially change descriptor. Work RVU should be maintained.
46900	Destruction of lesion(s) anus (eg, condyloma, papilloma, mulluscum contagiosum, herpetic vesicle), simple; chemical	1.81	1.81	CMD	The CMDs commented that code 46900 for destruction of anal lesion is overvalued because it	Colon and rectal surgeons report code 46900 when using anoscopy to treat lesions extending past the	1.81 (no change)

CPT Code	Descriptor	95 RVU	97 RVU	COMMENTER	COMMENT	RUC Rationale	Status of Code Proposal or RVW Recommendation
					involves the simple application of podophyllin to an anal or perianal lesion.	innersphincteric groove cephalad through the dentate line into the anal canal. There is also a follow-up appointment within the 10-day global period to evaluate the anoderm and repeat the anoscopy. Claims data indicate that colon and rectal and general surgeons provide 58% of these services. Dermatologists provide 17% of the services, however, and the RUC concluded that the service may then involve simple application of podophyllin to an anal or perianal lesion as described in the CMD comment. The RUC recommends that this issue be referred to CPT to consider revising the terminology to specify that the service involves treatment through anoscopy and/or add a new code for the more superficial procedure.	
54100	Biopsy of penis; cutaneous (separate procedure)	1.90	1.90	CMD	CMD recommended a decrease to 0.86 and compared this service to 11100 <i>Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise</i>	The RUC recommends that CPT review the biopsy codes and determine if site specific codes are necessary.	CPT coding proposal will be submitted to delete code in <u>CPT 1999</u> . Current Work RVU should be maintained for 1998.

CPT Code	Descriptor	95 RVU	97 RVU	COMMENTER	COMMENT	RUC Rationale	Status of Code Proposal or RVW Recommendation
					<i>listed (separate procedure); single lesion (rvu = 0.81) and 56605 Biopsy of vulva or perineum (separate procedure); one lesion (rvu = 0.86).</i>		
77420	Weekly radiation therapy management; simple	1.61	1.61	RUC	Potentially Overvalued Service	The RUC recommends that the current values be maintained on an interim basis until the radiation oncology codes are reviewed by the CPT Editorial Panel.	CPT coding proposal will be submitted for <u>CPT 1999</u> . Current Work RVU should be maintained for 1998.
77425	Weekly radiation therapy management; intermediate	2.44	2.44	RUC	Potentially Overvalued Service	The RUC recommends that the current values be maintained on an interim basis until the radiation oncology codes are reviewed by the CPT Editorial Panel.	CPT coding proposal will be submitted for <u>CPT 1999</u> . Current Work RVU should be maintained for 1998.
77430	Weekly radiation therapy management; complex	3.60	3.60	RUC	Potentially Overvalued Service	The RUC recommends that the current values be maintained on an interim basis until the radiation oncology codes are reviewed by the CPT Editorial Panel.	CPT coding proposal will be submitted for <u>CPT 1999</u> . Current Work RVU should be maintained for 1998.
93621	Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters; with left atrial recordings from coronary sinus or left atrium, with or without pacing	12.66	12.66	ACC	This medical complexity of this service has increased considerable since the code was first developed. Recent medical practice frequently involves a more technically difficult and risky service utilizing a transseptal approach to the left atrium. This code should	The RUC agreed to refer this code to CPT based on the changing technology of this procedure. The Editorial Panel should consider splitting the code into several codes.	CPT coding proposal will be submitted for <u>CPT 1999</u> . Current Work RVU should be maintained for 1998.

CPT Code	Descriptor	95 RVU	97 RVU	COMMENTER	COMMENT	RUC Rationale	Status of Code Proposal or RVW Recommendation
					be split into two distinct codes and appropriately valued.		

November 1, 1996

Ms. Celeste Kirschner
Director, Dept. of Coding
and Nomenclature
American Medical Association
515 N. State Street
Chicago, IL 60610

Dear Ms. Kirschner,

HCFA has requested clarification of code #31090 Sinusotomy combined, 3 or more sinuses. This was discussed at the recent Academy CPT Terminology Committee Meeting and it was recommended that the code be editorially revised to read "Sinusotomy combined, 3 or more sinuses (unilateral).

Please let me know if you think this adequately clarifies this code.

Sincerely

James H. Kelly, M.D., F.A.C.S.
Chairman
Terminology and Coding Committee
American Academy of Otolaryngology-
Head and Neck Surgery

JHK/srn

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COLON AND RECTAL SURGEONS

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April 18, 1997

Grant Rodkey, M.D.
American Medical Association
Department of Physician Payment Systems
515 N. State Street
Chicago, IL 60610

FAX #: 312-464-5849

Dear Dr. Rodkey:

The American Society of Colon and Rectal Surgeons wishes to comment regarding the proposal of the Carrier Medical Directors. The Carrier Medical Directors have suggested that CPT Code 46900, destruction of lesion in the anus, may be overvalued. The Carrier Medical Directors feel that this involves the simple application of Podophyllin to the anal or perianal lesion. They feel that a relative value of 1.81 is an overvalued service.

The American Society of Colon and Surgeons feel that CPT Code 46900 is not an overvalued service. Patients presenting with the most difficult lesions, condyloma, are patients who require an adequate history and physical, along with a destruction of the anal lesions. It has been a Carrier policy to only provide reimbursement for the destruction of anal lesions without an appropriate separate evaluation and management service reimbursement. Thus, CPT Code 46900 represents the initial history, physical assessment and treatment of the condyloma lesion. During the course of treatment, it is essential that the entire anoderm be examined. This involves treatment in conjunction with diagnostic anoscopy, which is also not separately coded or reimbursed. The anoscopic examination is to exclude cephalad extension of the infectious process. The most common condition associated with CPT Code 46900 represents a sexually transmitted disease. After establishing this diagnosis, counseling the patient for treatment and providing the necessary treatment, the physician has continued counseling concerning the underlying disease process. Oftentimes this counseling involves establishing that this is a sexually transmitted disease and may be related to

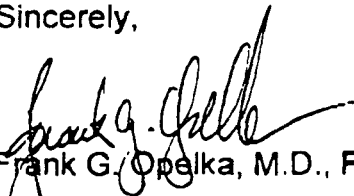
Grant Rodkey, M.D.
April 18, 1997
Page Two

human immune viral conditions (HIV). It is also important to remember that CPT Code 46900 represents a 10-day global period. After initial treatment with Bichloracetic Acid or Podophyllin, these patients often have significant problems with pruritus ani. During the 10-day global period, patients may return to the office for follow up visits related to the treatment within the 10-day global period. Oftentimes these patients return calls to the office during the 10-day period for further counseling regarding the underlying illness or the complications of the treatment themselves.

As claims data indicates that colorectal surgeons provide 58% of these services, this suggests that the destruction of lesions of the anus are associated with the anoscopic examination, the history and physical as provided above, and the counseling during the entire 10 day global period. It is because of all of these factors that the American Society of Colon and Rectal Surgeons strongly recommend that RUC consider that this is not an overvalued service.

I appreciate the opportunity to comment to the RUC. If you have any further questions regarding this matter, please contact me directly.

Sincerely,



Frank G. Opelka, M.D., FACS

FGO/mmt

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
FIVE-YEAR REVIEW PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 46900 Global Period: 10 Current RVW: 1.81 Recommended RVW 1.81

CPT Descriptor: Destruction of lesion(s), anus, simple; chemical

Source and Summary of Comment to HCFA on this service: CMD overvalued Rec'd RVW= 0.56

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 28 year old bisexual male presents with condyloma. The condyloma encompasses the anal verge and extends past the innersphincteric groove cephalad through the dentate line into the anal canal. The process involves the entire anus circumferentially and requires vigorous placement of Bichloracetic acid to

Description of Pre-Service Work: Counsel the patient for the diagnosis and treatment with attendant risks.

Position the patient and prepare the treatment area.

Description of Intra-Service Work: Using anoscopy, identify all lesions within the anal canal and directly apply chemical treatment to the lesions - protecting all surrounding anoderm.

Description of Post-Service Work: Follow up appointment in 7-10 days to evaluate the anoderm - repeat anoscopy.

SURVEY DATA:

Specialty: American Society of Colon and Rectal Surgery

Sample Size: 80 Response Rate (%): 45 Median RVW: 2.0

25th Percentile RVW: 1.4 75th Percentile RVW: 3.0 Low: 1.0 High: 5

Median Pre-Service Time: 15 Median Intra-Service Time: 15

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 15 Low: 5 High: 60

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 10

ICU: 0 0

Other Hospital: 0 0

Office: 15 1

Vignette continued--all the involved anoderm with application through anoscopy. The entire length of teh procedure is approximately 15 minutes additional to the previous evaluation and management services.

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	46500	Injection of sclerosing solution, hemorrhoids	1.53
2)	46050	Incision and drainage, perianal abscess, superficial	1.14
3)			
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

RATIONALE

This code involves a brief history, physical and counseling prior to application of any chemical treatment. The treatment is uncomfortable and creates significant localized pruritus. The destruction of anal lesions typically requires application of the chemical agent through an anoscope. Diagnostic anoscopy carries an RVw = 0.50 and has no global. Code 46900 also involves a follow up office visit with repeat anoscopy within the ten day global as supported by the survey instrument. The survey and work components intrinsic to code 46900 support the survey median RVw of 2.0

The ASCRS recommends maintaining the current value of 1.81.

CMD Comments

30-Jun-95

Code: 46900

1995 RVUs: 1.81

Recommended RVUs: 0.56

Ratio: -0.69

Long Descriptor: Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical

Reference Set (y/n): N Global Period: 010 Frequency: 1,389 Impact: -1736.25

Source: 2 Year: 92 Public Comment Letter:

Reference Services:

	Short Descriptor	RVU	Global
46900			
17100	DESTRUCTION OF SKIN LESION	0.53	010

CMD Comment:

In most cases, this involves the simple application of podophyllin to an anal or perianal lesion, in most cases no more than 20 minutes total time. The recommended waiting period before a repeat application is seven to ten days; there should usually only be one visit per global period.

Societies Wishing to Survey: ASCRS

Societies Wishing to Comment: AAD, ACEP, ACS

Trends Analysis -- Beneficiary Information:

	Age75	Age85	NonWhite	Female	Disabled	ESRD	AD_RD	Rural
46900	17.6	2.9	2.9	35.3	58.8	0	0	5.9

Trends Analysis -- Frequency:

	QX92	QX94	Chg92_94
46900	1379	1450	2.5

Trends Analysis -- Site of Service:

	Pct in 92	Pct in 94	Chg92_94
46900	2.2	1	-0.6

Trends Analysis -- Specialty Mix:

	Specialty	PCT_94
46900		
	colon and rectal surger	36
	dermatology	16.7
	general surgery	22.3
	general/family practice	4.7
	group practices	2.5
	internal medicine	5.8
	obstetrics/gynecology	8.4

CMD Comments

30-Jun-95

Claims-Level Diagnosis Information:

	ICD9	Pct of Time Used	ICD9 Descriptor
46900			
	042	2.2	HUMAN IMMUNODEFICIENCY VIRUS (HI
	078	19.1	OTHER DISEASES DUE TO VIRUSES AND
	216	3.7	BENIGN NEOPLASM OF SKIN
	250	1.5	DIABETES MELLITUS

Harvard Data:

Comm	Modif	Packhv	Pack95	Hrvtotwk	Mfswk95	Ratio5h	Mfswk92
46900							
CMD		010	010	2.32	1.81	0.78	1.81

Harvard Data:

Comm	Mswk93	Mfswk94	Ratio2h	Ratio32	Ratio43	Ratio54	Recwk	Amacod
46900								
CMD	1.81	1.81	0.78	1.00	1.00	1.00	0.56	

Harvard Data:

Comm	Pack95	Hrvtotwk	Notetw	Pret	Svdpre	ltime	Notett	Imppt
46900								
CMD	010	2.32		13	*	28		

Harvard Data:

Comm	Svdimp	Sdvis	Svdsdvis	Sdvisdur	Hvis	Svdhvis	Hvisdur	Icuvis	Offvis
46900									
CMD		0.0	*	0	0.0	*	0	0.0	1.0

Harvard Data:

Comm	Svdoffd	Offvdur	Low_N	Recwk	Mfswk95	Sp	Phase	Twput	lwput
46900									
CMD	*	10		0.56	1.81	gs	3		0.052

interoffice
M E M O R A N D U M

to: Sherry Smith
from: Megan Cohen, Acting Director Health Policy, AUA
subject: CPT Issue Remaining from Five Year Review
date: April 4, 1997

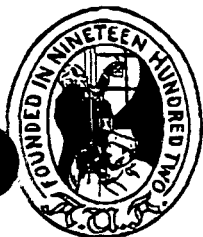
Currently, one urological code remains in limbo from the five year review - CPT Code 54100 - Biopsy of penis, cutaneous (separate procedure). Attached is a summary of a recommendation we will submit to CPT if it is approved at our April 9 Terminology Committee meeting. As you suggested, we ask that the RUC maintain the current work RVU for Code 54100 for the 1998 MFS until our CPT change can be carried out.

We will update you on our recommendation at the April 24-27 RUC meeting.

Thank you

Enclosure

cc: William F. Gee, MD, AUA RUC representative
Tracy Kiely, Health Policy Department



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To: Megan Cohen, Government Relations Coordinator

From: William F. Gee, M.D.

Date: April 1, 1997

Re: CPT 54100 ("Leftover" RUC Five-year Review Situation)

As indicated in the February 27, 1997, correspondence from the AMA/RUC, CPT Code 54100 is in a state of limbo. The CMD recommended a decrease to 0.86 RVW compared this service to 11100 (biopsy of skin) with an RVW of 0.81. The RUC recommended that CPT review the biopsy codes and determine if site-specific codes are necessary.

I would propose the following:

1. Delete CPT 54100 "biopsy of penis"; cutaneous (separate procedure).
2. Retain CPT 54105 "biopsy of penis"; cutaneous (separate procedure) deep structures with an RVW of 3.45.
3. The RVW for CPT 54100 is 1.9 at the present time.
4. Notify urologists that they should use CPT codes 11420 through 11426 when removing benign lesions of the penis. These codes are for "excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia," lesion diameters vary from 0.45 cm to over 4.0 cm. The RVUs for these vary from 1.01 up to 3.73, depending upon the size of the benign lesion removed. This CPT code covers "genitalia" and would seem to be more appropriate.
5. CPT 11100, referred to by the CMD, is for biopsy of the skin without removal of lesion. I can think of no instance in which a "biopsy of the penis" is not done without the specific reason of removing a particular lesion.



2
CPT Codes

- Summary:
1. Ask CPT to delete CPT code 54100.
 2. Notify urologists to use CPT 11420 through CPT 11426 when biopsying or excising benign lesions of the penis.
 3. Leave CPT 54105 for deep biopsy of the penis regardless of lesion size.

WFG:sw

cc: Tracy Kiely, Health Policy Department
H. Logan Holtgrewe, Chair, Health Policy Council

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April 16, 1997

Sherry L. Smith
Senior Policy Associate
American Medical Association
515 North State Street
Chicago, IL 60610

Dear Ms. Smith:

The ACC's Coding and Nomenclature Committee plans to review CPT code 93621 (comprehensive EP evaluation) and recommend the appropriate editorial revisions for the 1999 edition of CPT. This was an issue remaining from the five-year review process, thus, the ACC will not be making a proposal to the RUC on this code in April.

Should you require additional information, please contact our Health Policy Department at 1-800-435-9203.

Sincerely,

Marie E. Michnich, Dr.P.H.
Senior Associate Executive Vice President

cc: James Blankenship, M.D., F.A.C.C.
William Winters, M.D., F.A.C.C.
Alan Morgan

PB:98480:cfc

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AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Laparoscopy and Hysteroscopy - Tab 10

The RUC submitted recommendations to HCFA during the Five-Year Review of the RBRVS for increases in the work relative values for codes 56300 *Laparoscopy (peritoneoscopy), diagnostic; (separate procedure)* and 56305 *...with biopsy (single or multiple)*. HCFA did not adopt these recommendations because the RUC recommendations would create rank order anomalies within the laparoscopy and hysteroscopy family of codes. At the February 1997 RUC meeting, ACOG requested that the RUC review rank order anomalies that exist in these laparoscopic procedures. Doctor Grant Bagley recommended that the RUC review the issue and forward any comments or recommendations to HCFA.

After reaffirming their recommendations of 5.00 for 56300 and 5.30 for 56305, the RUC reviewed survey data from 125 obstetricians and gynecologists for each of these services. Establishing codes 56300 and 56305 as the base, the RUC recommends that 56301 *Laparoscopy, surgical; with fulguration of oviducts (with or without transection)* and 56302 *...with occlusion of oviducts by device (band, clip, or Falope ring)* be valued at 5.50 to account for the increased work of the additional office visit included in the 10 day global period. This recommendation is less than the survey median of 6.10.

The RUC was concerned that the survey medians for two codes, 56304 *Laparoscopy, surgical; with lysis of adhesions* and 56306 *...with aspiration (single or multiple)* were too high and recommends work rvus of 10.00 and 5.60 respectively, which approximate the 25th percentile of the survey median.

The RUC did accept the survey median for the majority of the services in this family of codes, including:

56303	<i>Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method</i>	10.50
56350	<i>Hysteroscopy, diagnostic (separate procedure)</i>	3.33
56351	<i>Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C</i>	4.75
56352	<i>with lysis of intrauterine adhesions (any method)</i>	6.17

56353	<i>with division or resection of intrauterine septum (any method)</i>	7.00
56354	<i>with removal of leiomyomata</i>	10.00
56355	<i>with removal of impact(ed) foreign body</i>	5.21
56356	<i>with endometrial ablation (any method)</i>	9.50
59150	<i>Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy</i>	11.20
59151	<i>with salpingectomy and/or oophorectomy</i>	11.10

The RUC agreed that these survey medians reflect an appropriate rank order between these services and codes 56300 and 56305. The survey median for code 56355 *Hysteroscopy, surgical; with removal of impact foreign body* is also equivalent to code 52315 *Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complex* (work rvu = 5.21), which serves as an appropriate cross-specialty reference service.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
56300	Laparoscopy (peritoneoscopy), diagnostic; (separate procedure)	000	5.00 RUC 5 Year Rev Rec Reaffirmed at Feb 97 RUC Meeting
56301	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	010	5.50
56302	Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring)	010	5.50
56303	Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method	010	10.50

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CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
56304	Laparoscopy, surgical; with lysis of adhesions (<u>salpingolysis,ovariolysis</u>) (<u>separate procedure</u>)	010	10.00
56305	Laparoscopy, surgical; with biopsy (single or multiple)	000	5.30 RUC 5 Year Rev Rec Reaffirmed at Feb 97 RUC Meeting
56306	Laparoscopy, surgical; with aspiration (single or multiple)	010	5.60
56350	Hysteroscopy, diagnostic (separate procedure)	000	3.33
56351	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D&C	000	4.75
56352	Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)	000	6.17
56353	Hysteroscopy, surgical; with division of resection of intrauterine septum (any method)	000	7.00
56354	Hysteroscopy, surgical; with removal of leiomyomata	000	10.00
56355	Hysteroscopy, surgical; with removal of impacted foreign body	000	5.21
56356	Hysteroscopy, surgical; with endometrial ablation (any method)	000	9.50
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	090	11.20
59151	Laprosopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy	090	11.10

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

CPT Code: 56301 Tracking Number: _____ Global Period: 010 Recommended RVW: 6.10

CPT Descriptor: Laparoscopy, surgical; with fulguration of oviducts (with or without transection)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25 year old G3P3 requests sterilization. After general anesthesia, a pelvic examination under anesthesia is performed, then a uterine manipulator is placed on the cervix. She undergoes laparoscopy and both tubes are fulgurated in the isthmic portion. She receives routine post-operative care during the 10 day global period.

Description of Pre-Service Work: Pre-service work begins after the decision to operate is made and continues until the time of the procedure. This activity includes reviewing the previous work-up, including consulting with the referring physician, if necessary, and other health care professionals, such as the anesthesiologist; taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; and communicating with the patient (and/or her family) to explain the indications for the procedure, as well as the operative risks and benefits, and to obtain informed consent. The physician admits the patient to the hospital (or surgery center), prepares the hospital records and chart in accordance with hospital policy, checks on the patient, and reviews records prior to the surgery. Other preoperative services include scheduling the operation, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operating suite.

Description of Intra-Service Work: After induction of anesthesia, a bimanual pelvic examination is done to assess uterine size, position, and mobility before the insertion of a uterine cannula. The adnexa and posterior cul de sac are palpated for the presence of masses or nodularity. Exposure of the cervix is obtained and the cervix is dilated, if necessary. The anterior lip of the cervix is grasped with a tenaculum attached to an intrauterine cannula. The bladder is drained with a catheter. An intraumbilical incision is made. The Veress needle is inserted and appropriate placement checked. Pneumoperitoneum is achieved with insufflation of CO₂ gas. Once satisfactory displacement of organs is achieved, the laparoscopic trocar and sleeve are inserted through the abdominal wall. The trocar is removed from the sleeve, proper placement is documented as the operating laparoscope is advanced down the trocar sleeve into the pelvis and the viscera are inspected to check for evidence of trauma. The CO₂ tubing is connected to the trocar. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation and venous return. Once the laparoscope has been inserted, a second trocar may be placed for ancillary instruments. The entire abdomen and pelvis are viewed systematically and pathology noted. It may be photodocumented. Upon completion of the exploration, additional trocars are placed under direct vision as needed. Each fallopian tube is identified and traced to its fimbriated end. The mid-portion of each tube is then completely coagulated, while making sure that no adjoining structures or bowel are damaged. The tubes may be transected. Meticulous hemostasis is maintained and the peritoneal cavity is irrigated. Ancillary trocars are then removed under direct vision to ensure no abdominal wall vascular injury or hemorrhage. The pneumoperitoneum is evacuated. The fascia may be closed separately, then the skin wounds are closed. The instruments are removed from the vagina. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work: Post-service work begins in the operating room after skin closure with the application of sterile dressings. Post-service work includes monitoring the patient's stability in the recovery room; communicating with the family and other health care professionals (including written and oral reports and orders); ordering and reviewing of post-operative radiographs and laboratory studies; careful attention to fluid-volume and electrolyte status; monitoring and care of the incision; monitoring, maintaining, and removing all tubes, drains, and catheters; antibiotic and pain medication management; and all other hospital visits and services performed by the surgeon. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge visits for this procedure for 10 days after the day of the operation are considered part of the post-service work, including removal of sutures; ordering and evaluating periodic imaging and laboratory studies, if needed; obtaining and reviewing all final surgical histopathology results; further coordination of care with a referring physician, and antibiotic and pain medication adjustments.

SURVEY DATA:Specialty: ACOG AND ASRMSample Size: 500 Response Rate (%): 125 (25%) Median RVW: 6.0025th Percentile RVW: 5.25 75th Percentile RVW: 8.10 Low: 2.93 High: 12.00Median Pre-Service Time: 40 Median Intra-Service Time: 3525th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 45 Low: 10 High: 75Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 20ICU: Other Hospital: Office: 151**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	56315	Laparoscopy, surgical ; appendectomy	8.25
2)	58740	Lysis of adhesions (salpingolysis, ovariolysis)	5.28
3)	56307	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy)	10.68

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

56301 has a similar level of intensity as 56315, but requires slightly less intra-service and post-service time. Intensity for 56301 is lower and less intra-service time is required than for 56307 because less pathology is encountered, there is less risk of damage, and the entire tube is not removed. The committee felt that 56301 and 56302 were equivalent in work and should be assigned the same value. Therefore the committee recommends 6.10 RVUs for both 56301 and 56302, the average of the median survey results for the two codes.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
56301	40	35	20	3	3	3
56315	45	45	30	3	3	3
58740	40	40	25	3	3	3
56307	45	45	20	4	4	4

ADDITIONAL RATIONALE

Pre-Service	Average of 99221 and 99222	1.71
Intra-Service (time)	35 min. X 0.06 RVUs per min.	2.10
Intra-Service (bundled procedures)	57410 (Pelvic exam under anesthesia) x 50%	0.88
Post-Service (Hospital)	99238	1.28
Post-Service (Office)	99213	0.67
Total		<u>6.64</u>

0.06 RVUs per minute is the intra-service work per unit time (IWPUT) for a D&C

FREQUENCY INFORMATION

How was this service previously reported? Not applicable

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not available

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 56302 Tracking Number: _____ Global Period: 010 Recommended RVW: 6.10

CPT Descriptor: Laparoscopy, surgical; with occlusion of oviducts by device(eg, band, clip, or Falope ring)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25 year old G3P3 requests sterilization. After general anesthesia, a pelvic examination is performed, then a uterine manipulator is placed on the cervix. She undergoes laparoscopy and both tubes are occluded in the isthmic portion by placement of a ring or clip. She receives routine post-operative care during the 10 day global period.

Description of Pre-Service Work: Pre-service work begins after the decision to operate is made and continues until the time of the procedure. This activity includes reviewing the previous work-up, including consulting with the referring physician, if necessary, and other health care professionals, such as the anesthesiologist; taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; and communicating with the patient (and/or her family) to explain the indications for the procedure, as well as the operative risks and benefits, and to obtain informed consent. The physician admits the patient to the hospital (or surgery center), prepares the hospital records and chart in accordance with hospital policy, checks on the patient, and reviews records prior to the surgery. Other preoperative services include scheduling the operation, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operating suite.

Description of Intra-Service Work: After induction of anesthesia, a bimanual pelvic examination is done to assess uterine size, position, and mobility before the insertion of a uterine cannula. The adnexa and posterior cul de sac are palpated for the presence of masses or nodularity. Exposure of the cervix is obtained and the cervix is dilated, if necessary. The anterior lip of the cervix is grasped with a tenaculum attached to an intrauterine cannula. The bladder is drained with a catheter. An intraumbilical incision is made. The Veress needle is inserted and appropriate placement checked. Pneumoperitoneum is achieved with insufflation of CO₂ gas. Once satisfactory displacement of organs is achieved, the laparoscopic trocar and sleeve are inserted through the abdominal wall. The trocar is removed from the sleeve, proper placement is documented as the operating laparoscope is advanced down the trocar sleeve into the pelvis and the viscera are inspected to check for evidence of trauma. The CO₂ tubing is connected to the trocar. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation and venous return. Once the laparoscope has been inserted, a second trocar may be placed for ancillary instruments. The entire abdomen and pelvis are viewed systematically and pathology noted. It may be photodocumented. Upon completion of the exploration, additional trocars are placed under direct vision as needed. Each fallopian tube is identified and traced to its fimbriated end. The mid-portion of each tube is identified and a band or clip placed while making sure that no adjoining structures or bowel are damaged. Meticulous hemostasis is maintained and the peritoneal cavity is irrigated. Ancillary trocars are then removed under direct vision to ensure no abdominal wall vascular injury or hemorrhage. The pneumoperitoneum is evacuated. The fascia may be closed separately, then the skin wounds are closed. The instruments are removed from the vagina. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work: Post-service work begins in the operating room after skin closure with the application of sterile dressings. Post-service work includes monitoring the patient's stability in the recovery room; communicating with the family and other health care professionals (including written and oral reports and orders); ordering and reviewing of post-operative radiographs and laboratory studies; careful attention to fluid-volume and electrolyte status; monitoring and care of the incision; monitoring, maintaining, and removing all tubes, drains, and catheters; antibiotic and pain medication management; and all other hospital visits and services performed by the surgeon. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge visits for this procedure for 10 days after the day of the operation are considered part of the post-service work, including removal of sutures; ordering and evaluating periodic imaging and laboratory studies, if needed; obtaining and reviewing all final surgical histopathology results; further coordination of care with a referring physician, and antibiotic and pain medication adjustments.

SURVEY DATA:Specialty: ACOG AND ASRMSample Size: 500 Response Rate (%): 122 (24.4%) Median RVW: 6.2025th Percentile RVW: 5.25 75th Percentile RVW: 8.18 Low: 2.50 High: 12.30Median Pre-Service Time: 40 Median Intra-Service Time: 3525th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 45 Low: 15 High: 80Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 20ICU: Other Hospital: Office: 15 1**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	56315	Laparoscopy, surgical; appendectomy	8.25
2)	58740	Lysis of adhesions (salpingolysis, ovariolysis)	5.28
3)	56307	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy)	10.68

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

56302 has a similar level of intensity as 56315, but requires slightly less intra-service and post-service time. Intensity for 56302 is lower and less intra-service time is required than for 56307 because less pathology is encountered, there is less risk of damage, and the entire tube is not removed. The committee felt that 56301 and 56302 were equivalent in work and should be assigned the same value. Therefore the committee recommends 6.10 RVUs for both 56301 and 56302, the average of the median survey results for the two codes.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
56302	40	35	20	3	3	3
56315	45	45	30	3	3	3
58740	40	60	25	3	3	3
56307	45	60	20	4	4	4

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

Pre-Service	average of 99221 and 99222	1.71
Intra-Service (time)	35 min. X 0.06 RVUs per min.	2.10
Intra-Service (bundled procedures)	57410 (Pelvic exam under anesthesia) x 50%	0.88
Post-Service (Hospital)	99238	1.28
Post-Service (Office)	99213	0.67
Total		<u>6.64</u>

0.06 RVUs per minute is the intra-service work per unit time (IWPUT) for a D&C

FREQUENCY INFORMATION

How was this service previously reported? Not applicable

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not available

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 56303 Tracking Number: Global Period: 010 Recommended RVW: 11.67

CPT Descriptor: Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera or peritoneal surface by any method

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 34 year GO female presented with progressively severe dysmenorrhea, pelvic pain, and dyspareunia. She had previously taken oral contraceptives which helped, but did not completely relieve the pain. She stopped oral contraceptives 9 months ago to begin trying to conceive. She misses 1-2 days of work with each menses. The patient is now taken to the operating room. After induction of general anesthesia, a pelvic examination under anesthesia is performed, and a uterine manipulator is placed on the cervix. Laparoscopy is performed, revealing multiple implants of endometriosis in the anterior and posterior cul de sac with scarring along both uterosacral ligaments. There are several implants on both the left and right posterior broad ligament. Both ovaries are free, but each has surface implants of endometriosis. The fallopian tubes appear normal and chromotubation is performed which demonstrates bilateral tubal patency. All of the lesions of endometriosis are vaporized, excised, or cauterized. She receives routine post-operative care during the 10 day global period.

Description of Pre-Service Work: Pre-service work begins after the decision to operate is made and continues until the time of the procedure. This activity includes reviewing the previous work-up, including consulting with the referring physician, if necessary, and other health care professionals, such as the anesthesiologist; taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; and communicating with the patient (and/or her family) to explain the indications for the procedure, as well as the operative risks and benefits, and to obtain informed consent. The physician admits the patient to the hospital (or surgery center), prepares the hospital records and chart in accordance with hospital policy, checks on the patient, and reviews records prior to the surgery. Other preoperative services include scheduling the operation, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operating suite.

Description of Intra-Service Work: After induction of anesthesia, a bimanual pelvic examination is done to assess uterine size, position, and mobility before the insertion of a uterine cannula. The adnexa and posterior cul de sac are palpated for the presence of masses or nodularity. Exposure of the cervix is obtained and the cervix is dilated, if necessary. The anterior lip of the cervix is grasped with a tenaculum attached to an intrauterine cannula. The bladder is drained with a catheter. An intraumbilical incision is made. The Veress needle is inserted and appropriate placement checked. Pneumoperitoneum is achieved with insufflation of CO₂ gas. Once satisfactory displacement of organs is achieved, the laparoscopic trocar and sleeve are inserted through the abdominal wall. The trocar is removed from the sleeve, proper placement is documented as the operating laparoscope is advanced down the trocar sleeve into the pelvis and the viscera are inspected to check for evidence of trauma. The CO₂ tubing is connected to the trocar. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation and venous return. Once the laparoscope has been inserted, a second trocar may be placed for ancillary instruments. The entire abdomen and pelvis are viewed systematically and pathology noted. It may be photodocumented. Upon completion of the exploration, additional trocars are placed under direct vision as needed. The lesions of endometriosis in the anterior cul de sac are excised, vaporized, or cauterized taking care not to damage the ureter, pelvic vessels, or colon. Lesions on the ovaries are excised, vaporized, or cauterized. Any specimens obtained are removed from the abdomen. Chromotubation is performed to assess tubal patency. Meticulous hemostasis is maintained and the peritoneal cavity is irrigated. Ancillary trocars are then removed under direct vision to ensure no abdominal wall vascular injury or hemorrhage. The pneumoperitoneum is evacuated. The fascia may be closed separately, then the skin wounds are closed. The instruments are removed from the vagina. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work: Post-service work begins in the operating room after skin closure with the application of sterile dressings. Post-service work includes monitoring the patient's stability in the recovery room; communicating with the family and other health care professionals (including written and oral reports and orders); ordering and reviewing of post-operative radiographs and laboratory studies; careful attention to fluid-volume and electrolyte status; monitoring and care of the incision; monitoring, maintaining, and removing all tubes, drains, and catheters; antibiotic and pain medication management; and all other hospital visits and services performed by the surgeon. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge visits for this procedure for 10 days after the day of the operation are considered

part of the post-service work, including removal of sutures; ordering and evaluating periodic imaging and laboratory studies, if needed; obtaining and reviewing all final surgical histopathology results; further coordination of care with a referring physician, and antibiotic and pain medication adjustments.

SURVEY DATA:

Specialty: ACOG

Sample Size: 500 Response Rate (%): 123 (24.6%) Median RVW: 10.50

25th Percentile RVW: 9.00 75th Percentile RVW: 12.45 Low: 3.09 High: 16.00

Median Pre-Service Time: 45 Median Intra-Service Time: 80

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 90 Low: 30 High: 180

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 30

ICU:

Other Hospital:

Office: 20 1

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	49200	Excision or destruction by any method of intra-abdominal or retroperitoneal tumors or cysts or endometriomas	9.19
2)	56315	Laparoscopy, surgical; appendectomy	8.25
3)	56307	Laparoscopy, surgical with removal of adnexal structures (partial or total oophorectomy)	10.68

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

56303 requires nearly twice as much intra-service time as 56315, and has higher levels of mental effort, technical skill and stress because it is a bilateral procedure, requiring retroperitoneal dissection around vital structures.

56303 requires greater intraservice time than 56307. Total work of 56303 falls somewhere between 49200 (9.19 RVUs) and 49201 (13.60 RVUs), the open procedure equivalents. The laparoscopic approach has only one coding option, so a composite of the two open codes approximates the work of 56303.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
56303	45	80	30	4	4	4
49200	37.5	70	30	4	4	4
56315	45	45	30	3	3	3
56307	45	60	20	4	4	4

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

The committee felt that the value yielded by the approach outlined below yielded a more appropriate value than the survey median.

Pre-Service	99222	2.14
Intra-Service (time)	80 min. X 0.75 RVUs per min.	6.00
Intra-Service (bundled procedures)	57410 (Pelvic exam under anesthesia) x 50 %	0.88
	58350 (Chromotubation) x 50 %	0.48
Post-Service (Hospital)	99238	1.28
Post-Service (Office)	average of 99213 and 99214	0.89
Total		<u>11.67</u>

0.075 RVUs per minute is the intra-service work per unit time (IWPUT) for an exploratory laparotomy

FREQUENCY INFORMATION

How was this service previously reported? Not applicable

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not available

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 56304 Tracking Number: Global Period: 010 Recommended RVW: 11.07

CPT Descriptor: Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30 year old female presents with complaints of mid-cycle pain and dysmenorrhea which has gotten progressively worse. She had an appendectomy for a ruptured appendix at the age of 18. She has been trying to conceive for 18 months without success. A recent HSG showed patent tubes. However, there was loculation of contrast around both tubes suggesting peritubal adhesions. The patient is now taken to the operating room. After general anesthesia, an examination under anesthesia is performed and a uterine manipulator is placed on the cervix. Laparoscopy is performed which shows multiple layers of filmy and dense adhesion throughout the pelvis. The tubes and ovaries are adherent to each other as well as to the pelvic sidewall. There are also adhesions between the posterior uterus and rectum. Chromotubation is performed which demonstrates bilateral tubal patency. Adhesiolysis is performed and at the conclusion of the operative session the tubes, ovaries, and uterus are completely free.

Description of Pre-Service Work: Pre-service work begins after the decision to operate is made and continues until the time of the procedure. This activity includes reviewing the previous work-up, including consulting with the referring physician, if necessary, and other health care professionals, such as the anesthesiologist; taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; and communicating with the patient (and/or her family) to explain the indications for the procedure, as well as the operative risks and benefits, and to obtain informed consent. The physician admits the patient to the hospital (or surgery center), prepares the hospital records and chart in accordance with hospital policy, checks on the patient, and reviews records prior to the surgery. Other preoperative services include scheduling the operation, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operating suite.

Description of Intra-Service Work: After induction of anesthesia, a bimanual pelvic examination is done to assess uterine size, position, and mobility before the insertion of a uterine cannula. The adnexa and posterior cul de sac are palpated for the presence of masses or nodularity. Exposure of the cervix is obtained and the cervix is dilated, if necessary. The anterior lip of the cervix is grasped with a tenaculum attached to an intrauterine cannula. The bladder is drained with a catheter. An intraumbilical incision is made. The Veress needle is inserted and appropriate placement checked. Pneumoperitoneum is achieved with insufflation of CO₂ gas. Once satisfactory displacement of organs is achieved, the laparoscopic trocar and sleeve are inserted through the abdominal wall. The trocar is removed from the sleeve, proper placement is documented as the operating laparoscope is advanced down the trocar sleeve into the pelvis and the viscera are inspected to check for evidence of trauma. The CO₂ tubing is connected to the trocar. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation and venous return. Once the laparoscope has been inserted, a second trocar may be placed for ancillary instruments. The entire abdomen and pelvis are viewed systematically and pathology noted. It may be photodocumented. Upon completion of the exploration, additional trocars are placed under direct vision as needed. Multiple layers of filmy and dense adhesions between the tube and ovary, tube and sidewall, and ovary and sidewall on each side are meticulously lysed to free the tube and ovary taking care not to damage the underlying structures such as ureter or pelvic vessels. The adhesions between the posterior uterus and rectum are meticulously lysed taking care not to damage the rectum. Chromotubation is performed to assess tubal patency. Meticulous hemostasis is maintained and the peritoneal cavity is irrigated. Ancillary trocars are then removed under direct vision to ensure no abdominal wall vascular injury or hemorrhage. The pneumoperitoneum is evacuated. The fascia may be closed separately, then the skin wounds are closed. The instruments are removed from the vagina. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work: Post-service work begins in the operating room after skin closure with the application of sterile dressings. Post-service work includes monitoring the patient's stability in the recovery room; communicating with the family and other health care professionals (including written and oral reports and orders); ordering and reviewing of post-operative radiographs and laboratory studies; careful attention to fluid-volume and electrolyte status; monitoring and care of the incision; monitoring, maintaining, and removing all tubes, drains, and catheters; antibiotic and pain medication management; and all other hospital visits and services performed by the surgeon. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge visits for this procedure for 10 days after the day of the operation are considered

CPT 56304

part of the post-service work, including removal of sutures; ordering and evaluating periodic imaging and laboratory studies, if needed; obtaining and reviewing all final surgical histopathology results; further coordination of care with a referring physician, and antibiotic and pain medication adjustments.

SURVEY DATA:Specialty: ACOG and ASRMSample Size: 500 Response Rate (%): 125 (25%) Median RVW: 12.0025th Percentile RVW: 10 75th Percentile RVW: 13.50 Low: 5.20 High: 20Median Pre-Service Time: 47.5 Median Intra-Service Time: 9025th Percentile Intra-Svc Time: 75 75th Percentile Intra-Svc Time: 120 Low: 5 High: 210Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 30ICU: Other Hospital: 5 5Office: 20 1**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	56344	Laparoscopy, surgical; with fimbrioplasty	12.5
2)	56307	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy)	10.68
3)	58740	Lysis of adhesions (salpingolysis, ovariolysis)	5.28

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

- 56304 is more time consuming than 56307 because disease often involves extensives arcs of the peritoneal and retroperitoneal spaces.
- More time consuming than 58740, requires greater degree of technical skill and entails more stress because of the laparoscopic approach. 58740 is undervalued, and, thus, not an appropriate comparison.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
56304	47.5	90	30	4	4	4
56344	45	90	30	4	4	4
56307	45	60	20	4	4	4
58740	40	60	25	3	3	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

Survey respondents rated this procedure higher than 56303. The committee felt that, although both procedures are currently significantly undervalued, the current rank order appropriately reflects the relative work of the procedures. 56304 requires less slightly less technical skill and entails less stress because, unlike 56303, the physician is not usually endangering vital structures and is not attempting to operate in the retroperitoneal space. Therefore, the committee recommends the 11.07 RVUs estimated through the alternative building block approach, a lower value than the survey median.

Pre-Service	99222	2.14
Intra-Service (time)	90 min x .06 RVUs per min	5.40
Intra-Service (bundled procedures)	57410 (Pelvic exam under anesthesia) x 50%	0.88
	58350 (Chromotubation) x 50%	0.48
Post-Service (Hospital)	99238	1.28
Post-Service (Office)	average of 99213 and 99214	0.89
Total		11.07

0.06 RVUs per minute is the intra-service work per unit time (IWPUT) for a D&C

FREQUENCY INFORMATION

How was this service previously reported? Not applicable

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not available

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 56306 Tracking Number: Global Period: 010 Recommended RVW: 6.50

CPT Descriptor: Laparoscopy, surgical; with aspiration (single or multiple)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30 year old female presented 2 months ago with complaints of left lower quadrant pain for the past week. Examination and ultrasound demonstrated a large left adnexal mass which appeared to be a simple ovarian cyst without signs of malignancy. She was followed. A repeat ultrasound performed 2 months after initial presentation and following a normal menses demonstrated a persistent cysts which had not changed in size. The patient is now taken to the operating room. After induction of general anesthesia, a pelvic examination is performed and a uterine manipulator is placed on the cervix. Laparoscopy is performed which show a simple appearing 5 cm cyst of the left ovary. The fallopian tubes appear normal and chromotubation is performed, demonstrating bilateral tubal patency. There are no findings to suggest that the cyst is malignant. A needle is passed through a second port and the cyst is aspirated of clear yellow fluid. She receives routine follow-up care during the 10 day global period.

Description of Pre-Service Work: Pre-service work begins after the decision to operate is made and continues until the time of the procedure. This activity includes reviewing the previous work-up, including consulting with the referring physician, if necessary, and other health care professionals, such as the anesthesiologist; taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; and communicating with the patient (and/or her family) to explain the indications for the procedure, as well as the operative risks and benefits, and to obtain informed consent. The physician admits the patient to the hospital (or surgery center), prepares the hospital records and chart in accordance with hospital policy, checks on the patient, and reviews records prior to the surgery. Other preoperative services include scheduling the operation, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operating suite.

Description of Intra-Service Work: After induction of anesthesia, a bimanual pelvic examination is done to assess uterine size, position, and mobility before the insertion of a uterine cannula. The adnexa and posterior cul de sac are palpated for the presence of masses or nodularity. Exposure of the cervix is obtained and the cervix is dilated, if necessary. The anterior lip of the cervix is grasped with a tenaculum attached to an intrauterine cannula. The bladder is drained with a catheter. An intraumbilical incision is made. The Veress needle is inserted and appropriate placement checked. Pneumoperitoneum is achieved with insufflation of CO₂ gas. Once satisfactory displacement of organs is achieved, the laparoscopic trocar and sleeve are inserted through the abdominal wall. The trocar is removed from the sleeve, proper placement is documented as the operating laparoscope is advanced down the trocar sleeve into the pelvis and the viscera are inspected to check for evidence of trauma. The CO₂ tubing is connected to the trocar. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation and venous return. Once the laparoscope has been inserted, a second trocar may be placed for ancillary instruments. The entire abdomen and pelvis are viewed systematically and pathology noted. It may be photodocumented. Upon completion of the exploration, additional trocars are placed under direct vision as needed. The cyst is carefully inspected for signs of malignancy. A needle is passed through a second port and the cyst completely aspirated of clear yellow fluid. Chromotubation is performed demonstrating patency of the right tube. Meticulous hemostasis is maintained and the peritoneal cavity is irrigated. Ancillary trocars are then removed under direct vision to ensure no abdominal wall vascular injury or hemorrhage. The pneumoperitoneum is evacuated. The fascia may be closed separately, then the skin wounds are closed. The instruments are removed from the vagina. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work: Post-service work begins in the operating room after skin closure with the application of sterile dressings. Post-service work includes monitoring the patient's stability in the recovery room; communicating with the family and other health care professionals (including written and oral reports and orders); ordering and reviewing of post-operative radiographs and laboratory studies; careful attention to fluid-volume and electrolyte status; monitoring and care of the incision; monitoring, maintaining, and removing all tubes, drains, and catheters; antibiotic and pain medication management; and all other hospital visits and services performed by the surgeon. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge visits for this procedure for 10 days after the day of the operation are considered part of the post-service work, including removal of sutures; ordering and evaluating periodic imaging and laboratory studies, if needed; obtaining and reviewing all final surgical histopathology results; further coordination of care with a referring physician, and antibiotic and pain medication adjustments.

SURVEY DATA:Specialty: ACOGSample Size: 500 Response Rate (%): 123 (24.6%) Median RVW: 6.5025th Percentile RVW: 5.40 75th Percentile RVW: 8.35 Low: 3.86 High: 14Median Pre-Service Time: 45 Median Intra-Service Time: 4525th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 60 Low: 15 High: 120Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 20ICU: Other Hospital: Office: 15 1CPT Code: 56306**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	58805	Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); abdominal approach	5.44
2)	56315	Laparoscopy, surgical; appendectomy	8.25
3)	58740	Lysis of adhesions (salpingolysis, ovariolysis)	5.28

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Intra-service time and intensity for 56306 are similar to 56315, but the appendectomy requires more post-service time, so the survey median seemed reasonable.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
56306	45	45	20	3	3	3
58805	40	45	20	3	3	2
56315	45	45	30	3	3	3
58740	40	60	25	3	3	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

Pre-Service	99222	2.14
Intra-Service (time)	45 min. X .06 RVUs per minute	2.70
Intra-Service (bundled procedures)	57410 (Pelvic exam under anesthesia) x 50%	0.88
	58350 (Chromotubation) x 50%	0.48
Post-Service (Hospital)	99238	1.28
Post-Service (Office)	99213	0.67
Total		<hr/> 8.15

0.06 RVUs per minute is the intra-service work per unit time (IWPUT) for a D&C

FREQUENCY INFORMATION

How was this service previously reported? Not applicable

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not applicable

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**CPT Code: 56350 Tracking Number: Global Period: 000 Recommended RVW: 3.33

CPT Descriptor: Hysteroscopy, diagnostic (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old post-menopausal woman presented with abnormal bleeding on combined continuous hormone replacement therapy. An endometrial biopsy was attempted, but yielded inadequate tissue for diagnosis. An endovaginal ultrasound revealed an endometrial thickness of greater than 1 cm with the suggestion of an intrauterine filling defect. Under adequate anesthesia, a pelvic examination is performed which documents a normal sized anteverted uterus. The cervix is dilated and the diagnostic hysteroscope is introduced into the endometrial cavity. A submucosal myoma is found with atrophic endometrium.

Description of Pre-Service Work: Pre-service work begins after the decision to perform the procedure is made and continues until the beginning of the procedure. This activity includes: reviewing the previous work-up; including consulting with a referring physician, if necessary, and with other health care professionals such as the anesthesiologist; taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; and communication with the patient (and/or her family) to explain the indications for the procedure as well as the risks and benefits and to obtain informed consent. The physician admits the patient to the hospital (or surgery center), prepares the hospital records and chart in accordance with hospital policy. Other pre-operative services include scheduling the procedure, dressing, scrubbing and waiting to begin the procedure. The physician must personally assure that all necessary equipment and supplies are available and compatible, including confirmation and mixing of solution for visualization (eg, 50% Dextran and 50% Glycine or saline). The physician must also confirm proper positioning of the patient and grounding of electrical equipment.

Description of Intra-Service Work: : Following induction of appropriate anesthesia, a bimanual pelvic examination is performed to assess uterine size, position, and mobility. The adnexa and posterior cul de sac are palpated for the presence of masses or nodularity. The bladder is drained with a catheter. The cervix is exposed, grasped, and dilated slightly larger than the scope. The uterine sound is passed. The scope is inserted and the physician confirms proper pressure setting of the pump or gravity flow to adequately distend the endometrial cavity. The entire endometrial cavity is examined, including the anterior, posterior, fundal, and lateral walls. The endocervical canal is examined. A submucosal myoma is found with atrophic endometrium. The hysteroscope is removed from the uterus. The cervix is checked for bleeding from a puncture site or laceration. If found, bleeding is controlled by suture, pressure or fulguration. All instruments are removed from the vagina and cervix. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work: Post-service work includes monitoring the patient's stability in the recovery room; writing orders and dictating an operative report; communicating with the patient, family, and other health care professionals (including written and oral reports and orders); ordering and reviewing post-operative radiographs and laboratory studies; careful attention to fluid-volume and electrolyte status; monitoring and care of the incision; monitoring, maintaining, and removing all tubes, catheters, and drains; antibiotic and pain medication management; and all other visits, and services performed by the surgeon. Discharge management includes the physician's final examination of the patient, instructions for continuing care, and preparation of discharge records

SURVEY DATA:Specialty: ACOG and ASRMSample Size: 500 Response Rate (%): 123 (24.6%) Median RVW: 3.3325th Percentile RVW: 2.90 75th Percentile RVW: 4 Low: 2 High: 10.68Median Pre-Service Time: 30 Median Intra-Service Time: 2525th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 30 Low: 5 High: 60

Median Post-Service Time:	<u> </u>	<u>Total Time</u>	<u>Number of Visits</u>
Day of Procedure:	<u>20</u>		
ICU:	<u> </u>		<u> </u>
Other Hospital:	<u> </u>		<u> </u>
Office:	<u> </u>		<u> </u>

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	2.91
2)	52000	Cystoscopy	2.01
3)	45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	3.78

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

56350 requires more physician work than 52000 because the cervix must be dilated and it is more difficult to maintain adequate distension of the uterus. In addition, 56350 entails more risk because of the risk of uterine perforation and bleeding due to the insertion of a large bore instrument. Therefore the survey median seemed appropriate.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
56350	30	25	20	3	3	2
58120	30	20	20	2	2	2
52000	30	15	15	2	2	2
45378	30	30	15	3	3	2

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

Pre-Service	99221	1.28
Intra-Service (time)	25 min x .06 RVUs per minute	1.5
Intra-Service (bundled procedures)	57410 (Pelvic exam under anesthesia) x 50%	0.88
Post-Service (Hospital)	99238	1.28
Total		4.94

0.06 RVUs per minute is the intra-service work per unit time (IWPUR) for a D&C

FREQUENCY INFORMATION

How was this service previously reported? Not applicable

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not available

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 56351 Tracking Number: Global Period: 000 Recommended RVW: 4.75

CPT Descriptor: Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D&C

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old post-menopausal woman presented with abnormal bleeding on combined continuous hormone replacement therapy. An endometrial biopsy was attempted, but yielded inadequate tissue for diagnosis. An endovaginal ultrasound revealed an endometrial thickness of greater than 1 cm with the suggestion of an intrauterine filling defect. Under adequate anesthesia, a pelvic examination is performed which documents a normal sized anteverted uterus. The cervix is dilated and the diagnostic hysteroscope is introduced into the endometrial cavity. An irregular polypoid mass is identified. The cervix is further dilated to admit the resectoscope and the entire lesion is resected. The cavity is then curetted with a sharp curette.

Description of Pre-Service Work: Pre-service work begins after the decision to perform the procedure is made and continues until the beginning of the procedure. This activity includes: reviewing the previous work-up; including consulting with a referring physician, if necessary, and with other health care professionals such as the anesthesiologist; taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; and communication with the patient (and/or her family) to explain the indications for the procedure as well as the risks and benefits and to obtain informed consent. The physician admits the patient to the hospital (or surgery center), prepares the hospital records and chart in accordance with hospital policy. Other pre-operative services include scheduling the procedure, dressing, scrubbing and waiting to begin the procedure. The physician must personally assure that all necessary equipment and supplies are available and compatible, including confirmation and mixing of solution for visualization (eg, 50% Dextran and 50% Glycine or saline). The physician must also confirm proper positioning of the patient and grounding of electrical equipment.

Description of Intra-Service Work: Following induction of appropriate anesthesia, a bimanual pelvic examination is performed to assess uterine size, position, and mobility. The adnexa and posterior cul de sac are palpated for the presence of masses or nodularity. The bladder is drained with a catheter. The cervix is exposed, grasped, and dilated slightly larger than the scope. The uterine sound is passed. The scope is inserted and the physician confirms proper pressure setting of the pump or gravity flow to adequately distend the endometrial cavity. The entire endometrial cavity is examined, including the anterior, posterior, fundal, and lateral walls. The endocervical canal is examined. An irregular polypoid mass is identified. The cervix is further dilated to admit the resectoscope and the entire lesion is resected. Bleeding points are coagulated. The cavity is then curetted with a sharp curette. The hysteroscope is removed from the uterus. The cervix is checked for bleeding from a puncture site or laceration. If found, bleeding is controlled by suture, pressure or fulguration. All instruments are removed from the vagina and cervix. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work: Post-service work includes monitoring the patient's stability in the recovery room; writing orders and dictating an operative report; communicating with the patient, family, and other health care professionals (including written and oral reports and orders); ordering and reviewing post-operative radiographs and laboratory studies; careful attention to fluid-volume and electrolyte status; monitoring and care of the incision; monitoring, maintaining, and removing all tubes, catheters, and drains; antibiotic and pain medication management; and all other visits, and services performed by the surgeon. Discharge management includes the physician's final examination of the patient, instructions for continuing care, and preparation of discharge records. The physician must also review the pathology report.

SURVEY DATA:Specialty: ACOG and ASRMSample Size: 500 Response Rate (%): 122 (24.4%) Median RVW: 4.7525th Percentile RVW: 3.90 75th Percentile RVW: 5.81 Low: 2.37 High: 14Median Pre-Service Time: 30 Median Intra-Service Time: 4025th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 60 Low: 10 High: 120Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 20

ICU: _____

Other Hospital: _____

Office: _____

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	2.91
2)	52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of: SMALL bladder tumor(s) (0.5 to 2.0 cm)	4.63
3)	52315	Cystourethroscopy, with removal of foreign body, calculus, or urethra of bladder (separate procedure); complicated	5.21

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

Total physician work for 56351 is somewhere between 52234 (4.63 RVUs) and 52235 (5.45RVUs). The mean RVUs for 52234 and 52235 is 5.04. The survey median seemed appropriate.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
56351	30	40	20	3	4	3
58120	30	20	20	2	2	2
52234	30	40	20	3	3	3
52315	30	37	20	3	3	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

Pre-Service	99221	1.28
Intra-Service (time)	40 min x .06 RVUs per min	2.4
Intra-Service (bundled procedures)	57410 (Pelvic exam under anesthesia) x 50%	0.88
Post-Service (Hospital)	99238	1.28
Total		5.84

0.06 RVUs per minute is the intra-service work per unit time (TWPOT) for a D&C

FREQUENCY INFORMATION

How was this service previously reported? Not applicable

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not available

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 56352 Tracking Number: Global Period: 000 Recommended RVW: 6.17

CPT Descriptor: Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 32 year old G3P0030 female has had 3 first trimester spontaneous abortions, all of which required a D&C. HSG revealed multiple thick irregular filling defects within the endometrial cavity suggestive of intrauterine adhesions. After general anesthesia, a pelvic examination is performed. The cervix is dilated and diagnostic hysteroscopy is performed, confirming the presence of intrauterine adhesions. The cervix is further dilated to admit the resectoscope or operating hysteroscope and the adhesions are lysed with the wire loop electrode or with scissors. At the conclusion of the case the cavity appears normal. A device (eg, Foley catheter) is placed into the cavity to separate the walls of the endometrial cavity.

Description of Pre-Service Work: Pre-service work begins after the decision to perform the procedure is made and continues until the beginning of the procedure. This activity includes: reviewing the previous work-up; including consulting with a referring physician, if necessary, and with other health care professionals such as the anesthesiologist; taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; and communication with the patient (and/or her family) to explain the indications for the procedure as well as the risks and benefits and to obtain informed consent. The physician admits the patient to the hospital (or surgery center), prepares the hospital records and chart in accordance with hospital policy. Other pre-operative services include scheduling the procedure, dressing, scrubbing and waiting to begin the procedure. The physician must personally assure that all necessary equipment and supplies are available and compatible, including confirmation and mixing of solution for visualization (eg, 50% Dextran and 50% Glycine or saline). The physician must also confirm proper positioning of the patient and grounding of electrical equipment.

Description of Intra-Service Work: Following induction of appropriate anesthesia, a bimanual pelvic examination is performed to assess uterine size, position, and mobility. The adnexa and posterior cul de sac are palpated for the presence of masses or nodularity. The bladder is drained with a catheter. The cervix is exposed, grasped, and dilated slightly larger than the scope. The uterine sound is passed. The scope is inserted and the physician confirms proper pressure setting of the pump or gravity flow to adequately distend the endometrial cavity. The entire endometrial cavity is examined, including the anterior, posterior, fundal, and lateral walls. The endocervical canal is examined. Inspection of the endometrial cavity confirms the presence of intrauterine adhesions. The cervix is further dilated to admit the resectoscope or operating hysteroscope and the adhesions are lysed with the wire loop electrode, scissors, or laser. Bleeding points are coagulated. At the conclusion of the case, the cavity appears normal. The hysteroscope is removed from the uterus. A device (eg, Foley catheter) is placed into the cavity to separate the walls of the endometrial cavity. The cervix is checked for bleeding from a puncture site or laceration. If found, bleeding is controlled by suture, pressure or fulguration. All instruments are removed from the vagina and cervix. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work: Post-service work includes monitoring the patient's stability in the recovery room; writing orders and dictating an operative report; communicating with the patient, family, and other health care professionals (including written and oral reports and orders); ordering and reviewing post-operative radiographs and laboratory studies; careful attention to fluid-volume and electrolyte status; monitoring and care of the incision; monitoring, maintaining, and removing all tubes, catheters, and drains; antibiotic and pain medication management; and all other visits, and services performed by the surgeon. Discharge management includes the physician's final examination of the patient, instructions for continuing care, and preparation of discharge records. The physician must also review the pathology report.

SURVEY DATA:Specialty: ACOGSample Size: 500 Response Rate (%): 123 (24.6%) Median RVW: 6.1725th Percentile RVW: 5 75th Percentile RVW: 8 Low: 3 High: 14Median Pre-Service Time: 40 Median Intra-Service Time: 6025th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 60 Low: 20 High: 150Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 25

ICU: _____

Other Hospital: _____

Office: _____

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	2.91
2)	58740	Lysis of adhesions (slapinolysis, ovariolysis)	5.28
3)	52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of MEDIUM bladder tumor(s) (2.0 to 5.0 cm)	5.45

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

56352 is more time consuming and technically demanding than 58120 because this procedure entails restoration of normal anatomy is a surgically scarred and partially or totally obliterated cavity. Expected anatomic landmarks are obscured or absent. The purpose of surgery is to restore fertility, so accurate and minimally destructive technique is required.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
56352	40	60	25	4	4	4
58120	30	20	20	2	2	2
58740	40	60	25	3	3	3
52235	30	45	20	3	3	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

Pre-Service	Average of 99221 and 99222	1.71
Intra-Service (time)	40 min x .075 RVUs per min	3.00
Intra-Service (bundled procedures)	57410 (Pelvic exam under anesthesia) x 50%	0.88
Post-Service (Hospital)	99238	1.28
Total		6.87

0.075 RVUs per minute is the intra-service work per unit time (IWPUT) for an exploratory laparotomy

FREQUENCY INFORMATION

How was this service previously reported? Not applicable

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not available

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 56353 Tracking Number: Global Period: 000 Recommended RVW: 7.00

CPT Descriptor: Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 32 year old G3P0 woman with three spontaneous pregnancy losses presented for evaluation. Hysterosalpingography revealed a thick uterine septum. Ultrasound documented a septate uterus with normal serosal uterine contour. The patient now undergoes hysteroscopy. After adequate anesthesia is obtained, an examination confirms a normal pelvic examination. The cervix is progressively dilated and the operative hysteroscope is introduced into the cervical canal. The septum is identified and resected in the avascular midline to the level of the uterine fundus. A device (eg, Foley catheter) is placed into the cavity to separate the walls of the endometrial cavity.

Description of Pre-Service Work: Pre-service work begins after the decision to perform the procedure is made and continues until the beginning of the procedure. This activity includes: reviewing the previous work-up; including consulting with a referring physician, if necessary, and with other health care professionals such as the anesthesiologist; taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; and communication with the patient (and/or her family) to explain the indications for the procedure as well as the risks and benefits and to obtain informed consent. The physician admits the patient to the hospital (or surgery center), prepares the hospital records and chart in accordance with hospital policy. Other pre-operative services include scheduling the procedure, dressing, scrubbing and waiting to begin the procedure. The physician must personally assure that all necessary equipment and supplies are available and compatible, including confirmation and mixing of solution for visualization (eg, 50% Dextran and 50% Glycine or saline). The physician must also confirm proper positioning of the patient and grounding of electrical equipment.

Description of Intra-Service Work: Following induction of appropriate anesthesia, a bimanual pelvic examination is performed to assess uterine size, position, and mobility. The adnexa and posterior cul de sac are palpated for the presence of masses or nodularity. The bladder is drained with a catheter. The cervix is exposed, grasped, and dilated slightly larger than the scope. The uterine sound is passed. The scope is inserted and the physician confirms proper pressure setting of the pump or gravity flow to adequately distend the endometrial cavity. The entire endometrial cavity is examined, including the anterior, posterior, fundal, and lateral walls. The endocervical canal is examined. The septum is identified and resected in the avascular midline to the level of the uterine fundus with scissors, wire loop electrode, or laser. Following resection, hemostasis is secured by fulguration and/or by insertion of a Foley catheter for tamponade. The hysteroscope is removed from the uterus. A device (eg, Foley catheter) is placed into the cavity to separate the walls of the endometrial cavity. The cervix is checked for bleeding from a puncture site or laceration. If found, bleeding is controlled by suture, pressure or fulguration. All instruments are removed from the vagina and cervix. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work: Post-service work includes monitoring the patient's stability in the recovery room; writing orders and dictating an operative report; communicating with the patient, family, and other health care professionals (including written and oral reports and orders); ordering and reviewing post-operative radiographs and laboratory studies; careful attention to fluid-volume and electrolyte status; monitoring and care of the incision; monitoring, maintaining, and removing all tubes, catheters, and drains; antibiotic and pain medication management; and all other visits, and services performed by the surgeon. Discharge management includes the physician's final examination of the patient, instructions for continuing care, and preparation of discharge records. The physician must also review the pathology report.

SURVEY DATA:Specialty: ACOGSample Size: 500 Response Rate (%): 121 (24.2%) Median RVW: 725th Percentile RVW: 5.45 75th Percentile RVW: 9 Low: 3.60 High: 14Median Pre-Service Time: 40 Median Intra-Service Time: 6025th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 60 Low: 20 High: 150Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 25

ICU: _____

Other Hospital: _____

Office: _____

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	2.91
2)	52277	Cystourethroscopy, with resection of external sphincter (sphincterotomy)	6.17
3)	52500	Transurethral resection of bladder neck (separate procedure)	7.82

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

56353 requires three times as much intra-service time as 58120. It is performed to correct congenital anomalies of the uterus. In-depth knowledge of potential variances is essential. The purpose of surgery is to restore fertility without creating scarring. The survey median seem appropriate.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
56353	40	60	25	4	4	4
58120	30	20	20	2	2	2
52277	30	45	20	3.5	3	3
52500	45	60	30	3	3.5	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

Pre-Service	99222	2.14
Intra-Service (time)	60 min x .06 RVUs per minute	3.60
Intra-Service (bundled procedures)	57410 (Pelvic exam under anesthesia) x 50%	0.88
Post-Service (Hospital)	99238	1.28
Total		7.90

0.06 RVUs per minute is the intra-service work per unit time (IWPUT) for a D&C

FREQUENCY INFORMATION

How was this service previously reported? Not applicable

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not available

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 56354 Tracking Number: Global Period: 000 Recommended RVW: 10.00

CPT Descriptor: Hysteroscopy, surgical; with removal of leiomyomata

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old nulligravid woman presented with profound menorrhagia, anemia, and primary infertility. Laboratory analysis documented ovulation. Ultrasound demonstrated several intrauterine filling defects. The anemia was corrected with iron supplementation and hormonal suppression of menses. The patient is now taken to the operating room. After adequate anesthesia is obtained, a pelvic examination demonstrates a smooth outer contour to the uterus which is found to be enlarged. The cervix is dilated and the resectoscope is introduced into the uterine cavity. Diagnostic hysteroscopy reveals two large submucous myomas. The myomas are each resected to the level of the adjacent endometrium. At the conclusion of the procedure, the entire endometrial cavity is normal and both tubal orifices are clearly identified and unobstructed.

Description of Pre-Service Work: Pre-service work begins after the decision to perform the procedure is made and continues until the beginning of the procedure. This activity includes: reviewing the previous work-up; including consulting with a referring physician, if necessary, and with other health care professionals such as the anesthesiologist; taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; and communication with the patient (and/or her family) to explain the indications for the procedure as well as the risks and benefits and to obtain informed consent. The physician admits the patient to the hospital (or surgery center), prepares the hospital records and chart in accordance with hospital policy. Other pre-operative services include scheduling the procedure, dressing, scrubbing and waiting to begin the procedure. The physician must personally assure that all necessary equipment and supplies are available and compatible, including confirmation and mixing of solution for visualization (eg. 50% Dextran and 50% Glycine or saline). The physician must also confirm proper positioning of the patient and grounding of electrical equipment.

Description of Intra-Service Work: Following induction of appropriate anesthesia, a bimanual pelvic examination is performed to assess uterine size, position, and mobility. The adnexa and posterior cul de sac are palpated for the presence of masses or nodularity. The bladder is drained with a catheter. The cervix is exposed, grasped, and dilated slightly larger than the scope. The uterine sound is passed. The scope is inserted and the physician confirms proper pressure setting of the pump or gravity flow to adequately distend the endometrial cavity. The entire endometrial cavity is examined, including the anterior, posterior, fundal, and lateral walls. The endocervical canal is examined. Hysteroscopy reveals two large submucous myomas. The myomas are each resected to the level of the adjacent endometrium with scissors, wire loop electrode, or laser. Bleeding points are coagulated. At the conclusion of the procedure, the entire endometrial cavity is normal and both tubal orifices are clearly identified and unobstructed. Hemostasis is secured by fulguration and/or by insertion of a Foley catheter for tamponade. The hysteroscope is removed from the uterus. The cervix is checked for bleeding from a puncture site or laceration. If found, bleeding is controlled by suture, pressure or fulguration. All instruments are removed from the vagina and cervix. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work: Post-service work includes monitoring the patient's stability in the recovery room; writing orders and dictating an operative report; communicating with the patient, family, and other health care professionals (including written and oral reports and orders); ordering and reviewing post-operative radiographs and laboratory studies; careful attention to fluid-volume and electrolyte status; monitoring and care of the incision; monitoring, maintaining, and removing all tubes, catheters, and drains; antibiotic and pain medication management; and all other visits, and services performed by the surgeon. Discharge management includes the physician's final examination of the patient, instructions for continuing care, and preparation of discharge records. The physician must also review the pathology report.

SURVEY DATA:Specialty: ACOGSample Size: 500 Response Rate (%): 124 (24.8%) Median RVW: 1025th Percentile RVW: 8 75th Percentile RVW: 11.62 Low: 3.70 High: 15Median Pre-Service Time: 40 Median Intra-Service Time: 7525th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 90 Low: 30 High: 180Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 30ICU: Other Hospital: Office: **KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	52240	Cystourethroscopy, with fultration (including cryosurgery or laser surgery) and/or resection of LARGE bladder tumor(s)	9.72
2)	58140	Myomectomy, excision of fibroid tumor of uterus, single or multiple (separate procedure); abdominal approach	13.79
3)	56309	Laparoscopy, surgical; with removal of leiomyomata, subserosal (single or multiple)	

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

56354 requires a similar level of technical skill as 56309 and 58140, but includes less post-operative care because of the 0 day global period. 56354 is similar to 52240. It carries the risk of fluid absorption and electrolyte changes. The survey median seemed appropriate.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
56354	40	75	30	4	5	4
52240	35	60	25	4	4	4
58140	60	100	45	4	4	4
56309	60	90	30	4	5	5

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

Pre-Service	99222	2.14
Intra-Service (time)	75 min x .075 RVUs per min	5.63
Intra-Service (bundled procedures)	57410 (Pelvic exam under anesthesia) x 50%	0.88
Post-Service (Hospital)	99238	1.28
Total		9.93

FREQUENCY INFORMATION

How was this service previously reported? Not applicable

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not available

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 56355 Tracking Number: Global Period: 000 Recommended RVW: 5.21

CPT Descriptor: Hysteroscopy, surgical; with removal of impacted foreign body

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 34 year old woman was referred by another physician for removal of an impacted IUD. The patient had the intrauterine device placed approximately 10 years earlier following her last pregnancy. She has remarried and desires another pregnancy. The referring physician attempted removal of the IUD unsuccessfully and broke the string above the cervical os. Attempts at retrieval in the office with an IUD hook have been unrewarding. Ultrasound demonstrated the intrauterine position of the device. The patient now undergoes hysteroscopy. Under adequate anesthesia, a pelvic examination is performed. The cervix is dilated and the operative hysteroscope is introduced into the endometrial cavity. The intrauterine device is located and noted to be partially imbedded in the wall of the uterus. The IUD is manipulated out of the uterine wall and removed from the uterine cavity.

Description of Pre-Service Work: Pre-service work begins after the decision to perform the procedure is made and continues until the beginning of the procedure. This activity includes: reviewing the previous work-up; including consulting with a referring physician, if necessary, and with other health care professionals such as the anesthesiologist; taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; and communication with the patient (and/or her family) to explain the indications for the procedure as well as the risks and benefits and to obtain informed consent. The physician admits the patient to the hospital (or surgery center), prepares the hospital records and chart in accordance with hospital policy. Other pre-operative services include scheduling the procedure, dressing, scrubbing and waiting to begin the procedure. The physician must personally assure that all necessary equipment and supplies are available and compatible, including confirmation and mixing of solution for visualization (eg, 50% Dextran and 50% Glycine or saline). The physician must also confirm proper positioning of the patient and grounding of electrical equipment.

Description of Intra-Service Work: Following induction of appropriate anesthesia, a bimanual pelvic examination is performed to assess uterine size, position, and mobility. The adnexa and posterior cul de sac are palpated for the presence of masses or nodularity. The bladder is drained with a catheter. The cervix is exposed, grasped, and dilated slightly larger than the scope. The uterine sound is passed. The scope is inserted and the physician confirms proper pressure setting of the pump or gravity flow to adequately distend the endometrial cavity. The entire endometrial cavity is examined, including the anterior, posterior, fundal, and lateral walls. The endocervical canal is examined. The intrauterine device is located and noted to be partially imbedded in the wall of the uterus. The IUD is manipulated out of the uterine wall and removed from the uterine cavity. The hysteroscope is removed from the uterus. The cervix is checked for bleeding from a puncture site or laceration. If found, bleeding is controlled by suture, pressure or fulguration. All instruments are removed from the vagina and cervix. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work: Post-service work includes monitoring the patient's stability in the recovery room; writing orders and dictating an operative report; communicating with the patient, family, and other health care professionals (including written and oral reports and orders); ordering and reviewing post-operative radiographs and laboratory studies; careful attention to fluid-volume and electrolyte status; monitoring and care of the incision; monitoring, maintaining, and removing all tubes, catheters, and drains; antibiotic and pain medication management; and all other visits, and services performed by the surgeon. Discharge management includes the physician's final examination of the patient, instructions for continuing care, and preparation of discharge records.

SURVEY DATA:Specialty: ACOGSample Size: 500 Response Rate (%): 123 (24.6%) Median RVW: 5.2125th Percentile RVW: 4 75th Percentile RVW: 6.39 Low: 2.20 High: 14.50Median Pre-Service Time: 30 Median Intra-Service Time: 4025th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 50 Low: 5 High: 180Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 20

ICU: _____

Other Hospital: _____

Office: _____

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	2.91
2)	52315	Cystourethroscopy, with removal of foreign body, calculus or ureteral stent from urethra of bladder (separate procedure); complicated	5.21
3)	52310	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra of bladder (separate procedure) simple	2.81

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

56355 is very similar to 52315. The survey median seemed appropriate.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
56355	30	40	20	3	3	3
58120	30	20	20	2	2	2
52315	30	37	20	3	3	3
52310	30	30	20	3	3	2

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

Pre-Service	99221	1.28
Intra-Service (time)	40 min x .06 RVUs per minute	2.40
Intra-Service (bundled procedures)	57410 (Pelvic exam under anesthesia) x 50%	0.88
Post-Service (Hospital)	99238	1.28
Total		5.84

0.06 RVUs per minute is the intra-service work per unit time (IWPUT) for a D&C

FREQUENCY INFORMATION

How was this service previously reported? Not applicable

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not available

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 56356 Tracking Number: Global Period: 000 Recommended RVW: 9.50

CPT Descriptor: Hysteroscopy, surgical; with endometrial ablation (any method)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 44 year old massively obese women was referred by another physician for management of menorrhagia to the point of significant anemia. Attempts to control her bleeding with cyclic progestins and antiprostaglandins have been unsuccessful. She is a heavy smoker and therefore not a candidate for oral contraceptives. An endometrial biopsy revealed no abnormality. The patients wants to avoid hysterectomy. She is now taken to the operating room. After adequate anesthesia is obtained a pelvic examination is performed. No obvious abnormality is appreciated, but the examination is compromised by the patient's size. The cervix is progressively dilated and a vigorous curettage is performed. The resectoscope is then introduced into the uterine cavity. A diagnostic hysteroscopy demonstrates a normal uterine cavity. The entire cavity is then meticulously coagulated.

Description of Pre-Service Work: Pre-service work begins after the decision to perform the procedure is made and continues until the beginning of the procedure. This activity includes: reviewing the previous work-up; including consulting with a referring physician, if necessary, and with other health care professionals such as the anesthesiologist; taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; and communication with the patient (and/or her family) to explain the indications for the procedure as well as the risks and benefits and to obtain informed consent. The physician admits the patient to the hospital (or surgery center), prepares the hospital records and chart in accordance with hospital policy. Other pre-operative services include scheduling the procedure, dressing, scrubbing and waiting to begin the procedure. The physician must personally assure that all necessary equipment and supplies are available and compatible, including confirmation and mixing of solution for visualization (eg, 50% Dextran and 50% Glycine or saline). The physician must also confirm proper positioning of the patient and grounding of electrical equipment.

Description of Intra-Service Work: Following induction of appropriate anesthesia, a bimanual pelvic examination is performed to assess uterine size, position, and mobility. The adnexa and posterior cul de sac are palpated for the presence of masses or nodularity. No obvious abnormality is appreciated, but the examination is compromised by the patient's size. The cervix is progressively dilated, the bladder is drained with a catheter, and a vigorous curettage is performed. The scope is inserted and the physician confirms proper pressure setting of the pump or gravity flow to adequately distend the endometrial cavity. The entire endometrial cavity is examined, including the anterior, posterior, fundal, and lateral walls. The endocervical canal is examined. The entire cavity is then meticulously coagulated by rollerball, resectoscope, or laser. The hysteroscope is removed from the uterus. The cervix is checked for bleeding from a puncture site or laceration. If found, bleeding is controlled by suture, pressure or fulguration. All instruments are removed from the vagina and cervix. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work: Post-service work includes monitoring the patient's stability in the recovery room; writing orders and dictating an operative report; communicating with the patient, family, and other health care professionals (including written and oral reports and orders); ordering and reviewing post-operative radiographs and laboratory studies; careful attention to fluid-volume and electrolyte status; monitoring and care of the incision; monitoring, maintaining, and removing all tubes, catheters, and drains; antibiotic and pain medication management; and all other visits, and services performed by the surgeon. Discharge management includes the physician's final examination of the patient, instructions for continuing care, and preparation of discharge records. The physician must also review the pathology report.

SURVEY DATA:Specialty: ACOGSample Size: 500 Response Rate (%): 118 (23.6%) Median RVW: 9.5025th Percentile RVW: 7.80 75th Percentile RVW: 10.50 Low: 3.55 High: 16Median Pre-Service Time: 40 Median Intra-Service Time: 6025th Percentile Intra-Svc Time: 45 75th Percentile Intra-Svc Time: 75 Low: 30 High: 160Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 30

ICU: _____

Other Hospital: _____

Office: _____

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	52240	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of: LARGE bladder tumor(s)	9.72
2)	52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of :MEDIUM bladder tumor(s) (2.0 to 5.0 cm)	5.45
3)	56307	Laparoscopy, surgical;with removal of adnexal structures (partial or total oophorectomy)	10.68

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

56356 requires a similar amount of time and level of intensity as 52240. However, the entire endometrium is fulgurated in contrast to one or more tumor sites. Success of the procedure depends upon complete destruction of the endometrium. Intra-service time and intensity for 56356 are very similar to 56307. However, 56356 includes less post-operative care because of the 0 day global period, so the survey median seemed appropriate.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
56356	40	60	30	4	4	4
52240	35	60	25	4	4	4
52235	30	45	20	3	3	3
56307	45	60	20	4	4	4

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

Pre-Service	99222	2.14
Intra-Service (time)	60 min x .075 RVUs per min	4.50
Intra-Service (bundled procedures)	57410 (Pelvic exam under anesthesia) x 50%	0.88
Post-Service (Hospital)	99238	1.28
Total		8.80

0.075 RVUs per minute is the intra-service work per unit time (IWPUT) for an exploratory laparotomy

FREQUENCY INFORMATION

How was this service previously reported? Not applicable

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not available

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 59150 Tracking Number: Global Period: 090 Recommended RVW: 11.65

CPT Descriptor: Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 34 year old G1 female with a history of prior tubal surgery present 6 weeks after her last menstrual period with left lower quadrant pain and vaginal spotting. Ultrasound revealed a small amount of fluid in the cul de sac and mass suspicious for a left tubal pregnancy. The patient is now taken to the operating room. After induction of general anesthesia, a pelvic examination is performed and a uterine manipulator is placed on the cervix. Laparoscopy is performed and reveals an unruptured left tubal pregnancy. The serosa of the tube is infiltrated with a dilute solution of pitressin. A linear salpingostomy (any method) is performed and hemostasis obtained with microtip bipolar electrosurgical energy. The patient receives follow-up care in the hospital and office during the 90 day global period.

Description of Pre-Service Work: Pre-service work begins after the decision to operate is made and continues until the time of the procedure. This activity includes reviewing the previous work-up, including consulting with the referring physician, if necessary, and other health care professionals, such as the anesthesiologist; taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; and communicating with the patient (and/or her family) to explain the indications for the procedure, as well as the operative risks and benefits, and to obtain informed consent. The physician admits the patient to the hospital (or surgery center), prepares the hospital records and chart in accordance with hospital policy, checks on the patient, and reviews records prior to the surgery. Other preoperative services include scheduling the operation, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operating suite.

Description of Intra-Service Work: After induction of anesthesia, a bimanual pelvic examination is done to assess uterine size, position, and mobility before the insertion of a uterine cannula. The adnexa and posterior cul de sac are palpated for the presence of masses or nodularity. Exposure of the cervix is obtained and the cervix is dilated, if necessary. The anterior lip of the cervix is grasped with a tenaculum attached to an intrauterine cannula. The bladder is drained with a catheter. An intraumbilical incision is made. The Veress needle is inserted and appropriate placement checked. Pneumoperitoneum is achieved with insufflation of CO₂ gas. Once satisfactory displacement of organs is achieved, the laparoscopic trocar and sleeve are inserted through the abdominal wall. The trocar is removed from the sleeve, proper placement is documented as the operating laparoscope is advanced down the trocar sleeve into the pelvis and the viscera are inspected to check for evidence of trauma. The CO₂ tubing is connected to the trocar. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation and venous return. Once the laparoscope has been inserted, a second trocar may be placed for ancillary instruments. The entire abdomen and pelvis are viewed systematically and pathology noted. It may be photodocumented. Upon completion of the exploration, additional trocars are placed under direct vision as needed. The serosa of the tube overlying the ectopic gestation is infiltrated with a dilute solution of pitressin. A linear incision (any method) is performed and the pregnancy evaluated utilizing irrigation and gentle traction, taking care not to further damage the tube. The products of conception are removed from the abdominal cavity. Meticulous hemostasis is maintained with microtip bipolar electrosurgical energy. The peritoneal cavity is copiously irrigated and all blood and fluid aspirated. Ancillary trocars are then removed under direct vision to ensure no abdominal wall vascular injury or hemorrhage. The pneumoperitoneum is evacuated. The fascia may be closed separately, then the skin wounds are closed. The instruments are removed from the vagina. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work: Post-service work begins in the operating room after skin closure with the application of sterile dressings. Post-service work includes monitoring the patient's stability in the recovery room; communicating with the family and other health care professionals (including written and oral reports and orders); ordering and reviewing of post-operative radiographs and laboratory studies; careful attention to fluid-volume and electrolyte status; monitoring and care of the incision; monitoring, maintaining, and removing all tubes, drains, and catheters; antibiotic and pain medication management; and all other hospital visits and services performed by the surgeon. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge visits for this procedure for 90 days after the day of the operation are considered part of the post-service work, including removal of sutures; ordering and evaluating periodic imaging and laboratory studies, if needed; obtaining and reviewing all final surgical histopathology results; further coordination of care with a referring physician, and antibiotic and pain medication adjustments. The patient is followed post-operatively until the beta HCG level is negative.

SURVEY DATA:Specialty: ACOGSample Size: 500 Response Rate (%): 124 (24.8%) Median RVW: 11.2025th Percentile RVW: 10.99 75th Percentile RVW: 12.50 Low: 6.50 High: 18.00Median Pre-Service Time: 60 Median Intra-Service Time: 7025th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 90 Low: 30 High: 180Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 30ICU: 0 0Other Hospital: 15 1Office: 30 2

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	59121	Surgical treatment of ectopic pregnancy;tubal or ovarian, without salpingectomy and/or oophorectomy, abdominal or vaginal approach	10.99
2)	56307	Laparoscopy, surgical;with removal of adnexal structures (partial or total oophorectomy)	10.68
3)	56343	Laparoscopy, surgical;with salpingostomy (salpingoneostomy)	13.34

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

59150 requires greater degree of technical skill and is more stressful than 59121 because of laparoscopic approach. 59150 is more time consuming and requires more post-operative follow-up care than 56307. Moreover, 59150 is performed on an emergency basis for an acutely ill patient. 59150 is less technically demanding than 56343 because the surgeons is not performing a delicate reconstruction of the tubal opening.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
59150	60	70	30	4	4	4
59121	60	75	30	4	3.5	3
56307	45	60	20	4	4	4
56343	60	90	30	4	4	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

The committee felt that survey respondents substantially underestimated the number of follow-up visits. Ectopic pregnancy patients must be followed on at least a weekly basis until beta HCG levels are negative. On average this process takes 20 to 45 days, requiring multiple follow-up visits, as rupture of persistent ectopic pregnancy can occur at any time, even when HCG levels are declining. Therefore, the committee felt that the survey mean of 11.65 was a more accurate reflection than the survey median of the total physician work associated with 59150.

Pre-Service	99223	2.99
Intra-Service (time)	70 min. X .075 RVUs per min	5.25
Intra-Service (bundled procedures)	57410 (Pelvic exam under anesthesia) x 50%	0.88
Post-Service (Hospital)	Average of 99232 and 99233	1.29
	99238	1.28
Post-Service (Office)	99213 x 2	1.34
Total		13.03

0.075 RVUs per minute is the intra-service work per unit time (IWPUT) for an exploratory laparotomy

FREQUENCY INFORMATION

How was this service previously reported? Not applicable

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not available

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 59151 Tracking Number: Global Period: 090 Recommended RVW: 11.53

CPT Descriptor: Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25 year old G2P1001 female presented to the emergency room 7 weeks after her last menstrual period with signs and symptoms of an ectopic pregnancy. The is now taken to the operating room.. After induction of general anesthesia, a pelvic examination is performed. A laparoscopy is performed, revealing that the right tube is dilated in the ampullary portion and actively bleeding from the area of rupture. There are approximately 750 ccs of blood in the pelvis. The tube and ovary are densely adherent to each other. Both the tube and ovary are free from the pelvic sidewall. A right salpingo-oophorectomy is performed. All of the blood is aspirated from the pelvis. The pelvis is copiously irrigated until clear. The patient receives routine post-operative care in the hospital and office during the 90 day global period.

Description of Pre-Service Work: Pre-service work begins after the decision to operate is made and continues until the time of the procedure. This activity includes reviewing the previous work-up, including consulting with the referring physician, if necessary, and other health care professionals, such as the anesthesiologist; taking a comprehensive history and performing a comprehensive examination to determine the patient's current medical status; and communicating with the patient (and/or her family) to explain the indications for the procedure, as well as the operative risks and benefits, and to obtain informed consent. The physician admits the patient to the hospital (or surgery center), prepares the hospital records and chart in accordance with hospital policy, checks on the patient, and reviews records prior to the surgery. Other preoperative services include scheduling the operation, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operating suite.

Description of Intra-Service Work: After induction of anesthesia, a bimanual pelvic examination is done to assess uterine size, position, and mobility before the insertion of a uterine cannula. The adnexa and posterior cul de sac are palpated for the presence of masses or nodularity. Exposure of the cervix is obtained and the cervix is dilated, if necessary. The anterior lip of the cervix is grasped with a tenaculum attached to an intrauterine cannula. The bladder is drained with a catheter. An intraumbilical incision is made. The Veress needle is inserted and appropriate placement checked. Pneumoperitoneum is achieved with insufflation of CO₂ gas. Once satisfactory displacement of organs is achieved, the laparoscopic trocar and sleeve are inserted through the abdominal wall. The trocar is removed from the sleeve, proper placement is documented as the operating laparoscope is advanced down the trocar sleeve into the pelvis and the viscera are inspected to check for evidence of trauma. The CO₂ tubing is connected to the trocar. Gas flow and intra-abdominal pressure are carefully monitored so as not to impair ventilation and venous return. Once the laparoscope has been inserted, a second trocar may be placed for ancillary instruments. The entire abdomen and pelvis are viewed systematically and pathology noted. It may be photodocumented. Upon completion of the exploration, additional trocars are placed under direct vision as needed. The ruptured ectopic gestation in the right tube is identified. The right infundibulopelvic ligament is cauterized and transected or isolated and suture ligated. The remainder of the broad ligament is then cauterized and transected or suture ligated and the specimen with products of conception removed from the abdominal cavity. Meticulous hemostasis is maintained and the peritoneal cavity is irrigated. Ancillary trocars are then removed under direct vision to ensure no abdominal wall vascular injury or hemorrhage. The pneumoperitoneum is evacuated. The fascia may be closed separately, then the skin wounds are closed. The instruments are removed from the vagina. The patient is transferred to a stretcher and escorted to the recovery room.

Description of Post-Service Work: Post-service work begins in the operating room after skin closure with the application of sterile dressings. Post-service work includes monitoring the patient's stability in the recovery room; communicating with the family and other health care professionals (including written and oral reports and orders); ordering and reviewing of post-operative radiographs and laboratory studies; careful attention to fluid-volume and electrolyte status; monitoring and care of the incision; monitoring, maintaining, and removing all tubes, drains, and catheters; antibiotic and pain medication management; and all other hospital visits and services performed by the surgeon. Discharge management includes the surgeon's final examination of the patient, instructions for continuing care, and preparation of discharge records. Additionally, all post-discharge visits for this procedure for 90 days after the day of the operation are considered part of the post-service work, including removal of sutures; ordering and evaluating periodic imaging and laboratory studies, if needed; obtaining and reviewing all final surgical histopathology results; further coordination of care with a referring physician, and antibiotic and pain medication adjustments. The patient is followed post-operatively until the beta HCG level is negative.

SURVEY DATA:Specialty: ACOGSample Size: 500 Response Rate (%): 125(25%) Median RVW: 11.1025th Percentile RVW: 10.74 75th Percentile RVW: 12.53 Low: 8.10 High: 19Median Pre-Service Time: 60 Median Intra-Service Time: 8025th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 90 Low: 30 High: 180Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 30ICU: 0 0Other Hospital: 15 1Office: 30 2

KEY REFERENCE SERVICE(S):

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach	10.68
2)	56307	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy)	10.68
3)	59121	Surgical treatment of ectopic pregnancy; tubal or ovarian, without salpingectomy and/or oophorectomy	10.99

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

59151 requires greater degree of technical skill and is more stressful than 59120 because of laparoscopic approach. 59151 is more time consuming and requires more post-operative follow-up care than 56307. Moreover, 59151 is performed on an emergency basis for an acutely ill patient.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
59151	60	80	30	4	4	4
59120	60	70	30	4	4	3
56307	45	60	20	4	4	4
59121	60	75	30	4	3.5	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

The committee felt that survey respondents substantially underestimated the number of follow-up visits. Ectopic pregnancy patients must be followed on at least a weekly basis until beta HCG levels are negative. On average this process takes 20 to 45 days, requiring multiple follow-up visits, as rupture of persistent ectopic pregnancy can occur at any time, even when HCG levels are declining. Therefore, the committee felt that the survey mean of 11.53 was a more accurate reflection than the survey median of the total physician work associated with 59151.

Pre-Service	99223	2.99
Intra-Service (time)	80 min. X .075 RVUs per min	6.00
Intra-Service (bundled procedures)	57410 (Pelvic exam under anesthesia) x 50%	0.88
Post-Service (Hospital)	Average of 99232 and 99233	1.29
	99238	1.28
Post-Service (Office)	99213 x 2	1.34
Total		13.78

0.075 RVUs per minute is the intra-service work per unit time (IWPUT) for an exploratory laparotomy

FREQUENCY INFORMATION

How was this service previously reported? Not applicable

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? Not available

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

RUC HCPAC REVIEW BOARD MEETING
February 1997

Psychophysiological Therapy Incorporating Biofeedback - Tab 2

At the April 1996 meeting, the Review Board adopted interim relative work values for new CPT codes describing psychophysiological therapy incorporating biofeedback equivalent to the 1996 work relative values for the psychotherapy codes 90843 and 90844. The American Psychological Association surveyed the new codes in the Fall of 1996 and presented new recommendations to the Review Board reflecting the increases to 90843 and 90844 in the 1997 MFS. After extensive discussion, the Review Board concluded that there is an incremental increase in providing psychotherapy with biofeedback.

Individual psychophysiological therapy is a therapeutic procedure incorporating biofeedback into the procedure of individual psychotherapy to allow physiological monitoring and re-learning simultaneously with treatment of psychotherapy. The procedure involves incremental work over psychotherapy without biofeedback, requiring technical skill and knowledge regarding the application of the procedure of biofeedback, and increased cognitive complexity regarding the interpretation and modification of the interplay between the patient's psychopathology and psychophysiological symptoms, disorder, or arousal. This procedure is not the substitution of biofeedback for psychotherapy time during the visit, rather it is the simultaneous application and integration of physiological monitoring during the procedure of psychotherapy. Examples of the types of patient that may be treated with this procedure would include pedophiles and pyromaniacs.

CPT Code	Tracking Number	CPT Descriptor	Global Period	4/96 Interim HCPAC Recommendation	5/97 Final HCPAC Recommendation
90875	RR40	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), <u>with psychotherapy</u> (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	XXX	1.11 (Interim)	1.20
90876	RR41	approximately 45-50 minutes	XXX	1.73 (Interim)	1.90

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

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

CPT Code: 9080X Tracking Number: FF10 Global Period: Recommended RVW: 1.50

CPT Descriptor: Individual psychophysiological therapy incorporating biofeedback training by any modality (face to face with the patient) (eg., insight oriented, behavior modifying or supportive psychotherapy) approximately 20 - 30 minutes.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

20 - 30 minute psychotherapy session, incorporating EMG biofeedback, with a 40-year-old woman whose referring physician has recently diagnosed as having fibromyalgia and severe tension headaches. Her pain symptoms presented and progressively intensified; and she has been increasingly depressed, since her mother had a stroke and she became care-giver. She is now reporting weight gain, marital discord, and that her headaches are interfering with her attendance at work.

Description of Pre-Service Work:

Preparing to see patient, preparation of biofeedback equipment, and review of records.

Description of Intra-Service Work:

History of problem and symptoms since last office visit and assessment of present physical symptoms and mental status. Assessment of treatment efficacy since last visit and review of assignments with patient (relaxation training log, daily pain/symptom index, etc.). Application of EMG biofeedback electrodes to target body region (eg, frontalis muscle). Patient guidance and instruction for integrating biofeedback stimulus and their physiological responses, and their ability to control maladaptive physiological reactivity. Psychotherapy for understanding psychological symptoms, increased adaptive coping and functioning, and reduction in both psychological and physiological symptoms. Active integration of biofeedback monitoring and patient physiological reactivity during psychotherapy, with patient gaining awareness and control of the relationship between their emotional functioning and their disabling headaches. Treatment may include relaxation induction techniques and direct behavioral suggestions regarding symptom reduction and symptom management, with interpretation of patient's present behavior and ability to change and control symptoms. Discussion of intersession assignments for cognitive and/or behavioral management. 20 - 30 minutes session length, with one-on-one interaction with treating therapist.

Description of Post-Service Work:

Arranging next visit. Documentation of services, including dictating report. Cleaning equipment and supplies. Communication with third party payors as necessary. Periodic telephonic consultation with referring physician, other professionals, and family for continuity of care. Review of new medical or lab studies when relevant.

SURVEY DATA:Specialty: American Psychological AssociationSample Size: 300 Response Rate (%): 11.3 (34) Median RVW: 1.2025th Percentile RVW: 1.14 75th Percentile RVW: 1.4 Low: 0.9 High: 2.1Median Pre-Service Time: 10 Min Median Intra-Service Time: 25 Min25th Percentile Intra-Svc Time: 20 Min 75th Percentile Intra-Svc Time: 30 Min Low: 15 High: 35Median Post-Service Time: 10 Min**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Current RVW</u>
1)	90843	Individual Psychotherapy, 20 - 30 min.	1.11	1.47
2)	99203	Office visit for eval and management of new Pt., Mod severity, 30 min.	1.14	1.34

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	Pre	Intra	Post	Mental	Technical Skill and Physical Effort	Psychological Stress
9080X	10	25	10	4	3	3
90843	5	25	9	3	3	3
99203	7	25	5	4	3	3

RATIONALE

We recommend an RVW of 1.50 for 9080X, rather than the median RVW of 1.20 obtained during this survey, as the RVW of the reference procedures have been re-weighted, with an increase of 32.4% for 90843 and 17.5% for 99203 over their published values during the survey interval. Individual psychophysiological therapy, 20-30 minutes, is a new code which fits within the family of psychiatric codes, and should be appropriately scaled within that family of codes. The median survey value of 9080X of 1.2 is 8.1% higher than the surveyed reference value for 90843 of 1.11, and 5.3% higher than the surveyed reference value for 99203 of 1.14. Using the relative relationship of the surveyed median RVW (1.2) for 9080X, to the re-weighted value for 90843 and to 99203, the appropriate RVW for 9080X should be between 1.59 and 1.41 respectively. The most widely used reference code for this procedure was 90843, and hence, would indicate that the RVW of 9080X should be 1.59. However, when adjusting for the relationship of 9080X to the entire Relative Value Scale with a non-psychiatric reference code, 99203, we recommend that the RVW for 9080X be 1.50, the midpoint between the adjusted respective weights.

9080X

FREQUENCY INFORMATION

How was this service previously reported? 90843, 90900, 90915

How often do physicians in your specialty perform this service? Survey Mean = 62 x yr

Estimate the number of times this service might be provided nationally in a one-year period: As this is a new code it is difficult to estimate the number of times it may be provided in a one-year period. However, as many practitioners have been coding this procedure as 90843, the total frequency of service provision is not expected to change, rather, it is expected that there will be more accurate coding of the procedure, with a concomitant reduction in utilization of 90843 when Individual psychophysiological therapy is provided.

Is this service performed by many physicians across the United States: Yes

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

CPT Code: 9081X Tracking Number: FF11 Global Period: _____ Recommended RVW: 2.20

CPT Descriptor: Individual psychophysiological therapy incorporating biofeedback training by any modality (face to face with the patient) (eg., insight oriented, behavior modifying or supportive psychotherapy): approximately 45 - 50 minutes.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

45-50 minute psychotherapy session, incorporating EMG biofeedback, with a 40-year-old woman whose referring physician has recently diagnosed as having fibromyalgia and severe tension headaches. Her pain symptoms presented and progressively intensified, and she has been increasingly depressed, since her mother had a stroke and she became care-giver. She is now reporting weight gain, marital discord, and that her headaches are interfering with her attendance at work.

Description of Pre-Service Work:

Preparing to see patient, preparation of biofeedback equipment, and review of records.

Description of Intra-Service Work:

History of problem and symptoms since last office visit and assessment of present physical symptoms and mental status. Assessment of treatment efficacy since last visit and review of assignments with patient (relaxation training log, daily pain/symptom index, etc.). Application of EMG biofeedback electrodes to target body region (eg, frontalis muscle). Patient guidance and instruction for integrating biofeedback stimulus and their physiological responses, and their ability to control maladaptive physiological reactivity. Psychotherapy for understanding psychological symptoms, increased adaptive coping and functioning, and reduction in both psychological and physiological symptoms. Active integration of biofeedback monitoring and patient physiological reactivity during psychotherapy, with patient gaining awareness and control of the relationship between their emotional functioning and their disabling headaches. Treatment may include relaxation induction techniques and direct behavioral suggestions regarding symptom reduction and symptom management, with interpretation of patient's present behavior and ability to change and control symptoms. Discussion of intersession assignments for cognitive and/or behavioral management. 45 - 50 minute session length, with one-on-one interaction with treating therapist.

Description of Post-Service Work:

Arranging next visit. Documentation of services, including dictating report. Cleaning equipment and supplies. Communication with third party payors as necessary. Periodic telephonic consultation with referring physician, other professionals, and family for continuity of care. Review of new medical or lab studies when relevant.

9081X

SURVEY DATA:Specialty: American Psychological AssociationSample Size: 300 Response Rate (%): 15% (45) Median RVW: 1.9025th Percentile RVW: 1.8 75th Percentile RVW: 2.23 Low: 1.3 High: 2.23Median Pre-Service Time: 10 Min Median Intra-Service Time: 50 Min25th Percentile Intra-Svc Time: 45 Min 75th Percentile Intra-Svc Time: 50 Min Low: 30 High: 60Median Post-Service Time: 10 Min**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>	<u>Current RVW</u>
1)	90844	Individual Psychotherapy, 45 - 50 min	1.73	2.00
2)	90855	Interactive Individual Psychotherapy	1.82	2.15

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

	Pre	Intra	Post	Mental	Technical Skill and Physical Effort	Psychological Stress
9081X	10	50	10	4	4	3
90844	5	50	8	3	3	3
90855	10	50	8	4	3	3

RATIONALE

We recommend an RVW of 2.20 for 9081X, rather than the median RVW of 1.90 obtained during this survey as the RVW of the reference procedures have been re-weighted, with an increase of 15.6% for 90844 and 18.1% for 90855 over their published values during the survey interval. Individual psychophysiological therapy, 45 - 50 min, is a new code which fits within the family of psychiatric codes, and should be appropriately scaled within that family of codes. The median survey value of 9081X of 1.9 is 9.8% higher than the surveyed reference value for 90844 of 1.73, and 4.4% higher than the surveyed reference value for 90855 of 1.82. Using the relative relationship of the surveyed median RVW (1.9) for 9081X, to the re-weighted value for 90844 and to 90855, the appropriate RVW for 9081X should be between 2.20 and 2.24 respectively. As the most widely used reference code for this procedure was 90844, we recommend that the RVW for 9081X be 2.20.

FREQUENCY INFORMATION

How was this service previously reported? 90844, 90900, 90915

How often do physicians in your specialty perform this service? Survey Mean = 216 x yr

Estimate the number of times this service might be provided nationally in a one-year period: As this is a new code it is difficult to estimate the number of times it may be provided in a one-year period. However, as many practitioners have been coding this procedure as 90844, the total frequency of service provision is not expected to change, rather, it is expected that there will be more accurate coding of the procedure, with a concomitant reduction in utilization of 90844 when Individual psychophysiological therapy is provided.

Is this service performed by many physicians across the United States: Yes

RUC HCPAC REVIEW BOARD
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Paring, Cutting, and Trimming of Nails - Tab C

Four new CPT codes for paring, cutting, or trimming of nails were created to replace codes 11050 *Paring or curettement of benign hyperkeratotic skin lesion with or without chemical cauterization (such as verrucae or clavi) not extending through the stratum corneum (eg, callus or wart) with or without local anesthesia; single lesion* (work rvu = .43), 11051 *...two to four lesions* (work rvu = .66), 11052 *...more than four lesions* (work rvu = .86), and M0101 *Cutting or removal of corns, calluses and/or trimming of nails, application of skin creams and other hygienic and preventive maintenance care (excludes debridement of nail(s))* (work rvu = 43). The Review Board recommends work rvus which are based on the survey medians of 60 podiatrists:

The survey medians appear appropriate when comparing 11055-11057 with 11720 *Debridement of nail(s) by any method(s); one to five* (work rvu = 0.32) and the destruction of lesion family of codes 17000-17004. The recommended work rvu for 11721 is equivalent to 99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.* (work rvu = 0.17).

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
11050	SS1	Paring or curettement of benign hyperkeratotic skin lesion with or without chemical cauterization (such as verrucae or clavi) not extending through the stratum corneum (eg, callus or wart) with or without local anesthesia; single lesion	000	N/A
11051	SS2	two to four lesions	000	N/A

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11719
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11052	SS3	more than four lesions (11050-11052 have been deleted. To report paring, see 110X1-110X3, or to report destruction, see 17000-17004.	000	N/A
•11055	SS4	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus), single lesion	000	0.43
•11056	SS5	two to four lesions	000	0.61
•11057	SS6	more than four lesions	000	0.79
•11719	SS7	Trimming of nondystrophic nails, any number	000	0.17

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

CPT Code: 110XX Tracking Number: SS4 Global Period: 000 Recommended RVW: 0.43

CPT Descriptor:

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 74 year-old hypertensive, non-insulin dependent diabetic female presents with a chronic recurring corn on the dorsolateral aspect of her fifth toe. The patient has unsuccessfully tried to treat the corn using over-the-counter remedies and changing shoe sizes and styles. The corn on the fifth toe is pare and a 1/8th inch felt aperture pad is cut and applied to the toe.

Description of Pre-Service Work:

- Pre-service evaluation, including review of pertinent medical records
- Brief medical update, including recent allergies and medications
- Review of treatment options
- Review procedure with patient
- Discuss possible complications or sequelae
- Prepare instruments, including disposable surgical blade, blade handle, tissue nippers, antiseptic, drapes, gloves, lighting, padding material and scissors
- Communicate with family or care giver

Description of Intra-Service Work:

- Inspect and palpate lesion for size, location, functional risks; depth
- Pare lesion
- Apply antiseptic to skin
- Determine type of padding and specific material needed to shield the toe
- Cut pad to fit toe and properly remove pressure point

Description of Post-Service Work:

- Instruct patient and/or care giver on appropriate home care
- Discuss future management of the condition
- Instruct on proper selection and sizing of footwear
- Instruct on importance of controlling concomitant medical conditions
- Completion of medical record
- Communication to primary care physician

SURVEY DATA:

Specialty: American Podiatric Medical Association

Sample Size: 59 Response Rate (%): 90 Median RVW: 0.43

25th Percentile RVW: 0.35 75th Percentile RVW: 0.56 Low: 0.27 High: 1.0

Median Pre-Service Time: 2 Median Intra-Service Time: 4

25th Percentile Intra-Svc Time: 3 75th Percentile Intra-Svc Time: 5 Low: 1 High: 10Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 5ICU: N/AOther Hospital: N/AOffice: N/ACPT Code: 110XX**KEY REFERENCE SERVICE(S):**

	CPT Code	CPT Descriptor	RVW
1)	11720	Debridement of nail(s) by any method(s); one to five	0.32
2)	11051	Paring or curettage of benign hyperkeratotic skin lesion with or without chemical cauterization (such as verrucae or clavi) not extending through the stratum corneum (eg, callus or wart) with or without local anesthesia; two to four lesions	0.66

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The pre-service and intra-service times of both reference procedures were greater than the time required for the 110XX. The post-service time was the same for all the procedures. The technical skill and physical effort, and psychological stress of 110XX was the same as reference procedure 11051, but greater than procedure 11720.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
11720	5	8	5	2	2	1
11051	5	10	5	2	3	2

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? M0101

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 200,000

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 110X1 Tracking Number: SS5 Global Period: 000 Recommended RVW: 0.61

CPT Descriptor:

Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); two to four lesions

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 69 year-old rheumatoid arthritic diabetic female presents with chronic recurring corns on the dorsolateral aspect of both fifth toes, and a callus beneath her second metatarsal head on her right foot. The patient has unsuccessfully self-treated the lesions with an emery board and over-the-counter foot remedies. The hyperkeratotic lesions are pare, and 1/8th inch felt aperture pads are cut and applied to the toes and a 1/4 inch felt aperture pad is applied to the bottom of the right foot.

Description of Pre-Service Work:

- Pre-service evaluation, including review of pertinent medical records
- Brief medical update, including recent allergies and medications
- Review of treatment options
- Review procedure with patient
- Discuss possible complications or sequelae
- Prepare instruments, including disposable surgical blade, blade handle, tissue nippers, antiseptic, drapes, gloves, lighting, padding material and scissors
- Communicate with family or care giver

Description of Intra-Service Work:

- Inspect and palpate lesion for size, location, functional risks, depth
- Pare lesion
- Apply antiseptic to skin
- Determine type of padding and specific material needed to shield the toe and foot
- Cut pads to fit and apply to properly remove pressure points

Description of Post-Service Work:

- Instruct patient and/or care giver on appropriate home care
- Discuss future management of the condition
- Instruct on proper selection and sizing of footwear
- Instruct on importance of controlling concomitant medical conditions
- Completion of medical record
- Communication to primary care physician

SURVEY DATA:

Specialty: American Podiatric Medical Association

Sample Size: 59 Response Rate (%): 90 Median RVW: 0.61

25th Percentile RVW: 0.49 75th Percentile RVW: 0.70 Low: 0.37 High: 1.2

CPT Code: 110X1

Median Pre-Service Time: 2 Median Intra-Service Time: 8

25th Percentile Intra-Svc Time: 6 75th Percentile Intra-Svc Time: 11 Low: 4 High: 15

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 5

ICU: N/A

Other Hospital: N/A

Office: N/A

CPT Code: 110X1

KEY REFERENCE SERVICE(S):

	CPT Code	CPT Descriptor	RVW
1)	11720	Debridement of nail(s) by any method(s);one to five	0.32
2)	11051	Paring or curettement of benign hyperkeratotic skin lesion with or without chemical cauterization (such as verrucae or clavi) not extending through the stratum corneum (eg, callus or wart) with or without local anesthesia; two to four lesions	0.66

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The pre-service time for 110X1 was less than either of the two reference procedures. The intra-service time of 110X1 was the same as 11720, but slightly less than 11051. The post-service time was the same for all procedures. The technical skill and physical effort, and psychological stress of 110X1 was the same as reference procedure 11051, but greater than procedure 11720.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psycho Stress
11720	5	8	5	2	2	1
11051	5	10	5	2	3	2

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? M0101

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1,400,000

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 110X2 Tracking Number: SS6 Global Period: 000 Recommended RVW: 0.79

CPT Descriptor:

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 71 year-old non-insulin dependent diabetic female presents with chronic recurring multiple hyperkeratotic lesions on both feet. The lesions are located on the dorsum of the second, third and fifth toes of both feet, and on the plantar aspect of both feet. The patient has tried cutting the lesions with a straight razor, and has used over-the-counter acid preparations. The lesions on both feet are pared, and 1/8th inch felt aperture pads are cut and applied to each toe and 1/4 inch felt pads are cut and applied to the plantar aspect of both feet.

Description of Pre-Service Work:

- Pre-service evaluation, including review of pertinent medical records
- Brief medical update, including recent allergies and medications
- Review of treatment options
- Review procedure with patient
- Discuss possible complications or sequelae
- Prepare instruments, including disposable surgical blade, blade handle, tissue nippers, antiseptic, drapes, gloves, lighting, padding material and scissors
- Communicate with family or care giver

Description of Intra-Service Work:

- Inspect and palpate lesions for size, location, functional risks, depth
- Pare lesion
- Apply antiseptic to skin
- Determine type of padding and specific material to shield toes and feet
- Cut pads to fit and apply to properly remove pressure points

Description of Post-Service Work:

- Instruct patient and/or care giver on appropriate home care
- Discuss future management of the condition
- Instruct on proper select and sizing of footwear
- Instruct on importance of controlling concomitant medical conditions
- Completion of medical record
- Communication to primary care physician

SURVEY DATA:

Specialty: American Podiatric Medical Association

Sample Size: 59 Response Rate (%): 90 Median RVW: 0.79

25th Percentile RVW: 0.66 75th Percentile RVW: 0.86 Low: 0.48 High: 1.3

110X2

CPT

Code:

Median Pre-Service Time: 2 Median Intra-Service Time: 15

25th Percentile Intra-Svc Time: 12 75th Percentile Intra-Svc Time: 18 Low: 8 High: 30

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 5

ICU: N/A

Other Hospital: N/A

Office: N/A

KEY REFERENCE SERVICE(S):

	CPT Code	CPT Descriptor	RVW
1)	11720	Debridement of nail(s) by any method(s);one to five	0.32
2)	11051	Paring or curettement of benign hyperkeratotic skin lesion with or without chemical cauterization (such as verrucae or clavi) not extending through the stratum corneum (eg, callus or wart) with or without local anesthesia;two to four lesions	0.66

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The pre-service time for 110X2 was less than either of the reference procedures. The median intra-service time was almost double 11720 and 50% greater than 11051. The post-service time was the same for all procedures. The mental effort and judgement, and technical skill and physical effort was the same as 11051, but the psychological stress associated with 110X2 was greater than 11051.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psycho Stress
11720	5	8	5	2	2	1
11051	5	10	5	2	3	2

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

CPT Code: 110X2

FREQUENCY INFORMATION

How was this service previously reported? M0101

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 200,000

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 117XX Tracking Number: SS7 Global Period: 000 Recommended RVW: 0.17

CPT Descriptor:

Trimming of non-dystrophic nails, any number

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 67 year-old obese diabetic female presents with ten hypertrophied nails. All ten nails are trimmed.

Description of Pre-Service Work:

- Pre-service evaluation, including review of medical records
- Brief medical update, including recent allergies and medication
- Review of treatment options
- Review procedure with patient
- Discuss possible complications
- Prepare instruments including nail nippers, nail rasp, curette, antiseptic, drapes, gloves, and lighting

Description of Intra-Service Work:

- Inspect length and thickness of nails, and periungual tissue
- Trim all toenails
- Apply antiseptic to nails and periungual tissue

Description of Post-Service Work:

- Instruct patient and/or care giver on appropriate home care
- Discuss future management of condition
- Instruct on importance of controlling concomitant medical conditions
- Communication to primary care physician

SURVEY DATA:

Specialty: American Podiatric Medical Association

Sample Size: 59 Response Rate (%): 90 Median RVW: 0.17

25th Percentile RVW: 0.12 75th Percentile RVW: 0.28 Low: 0.10 High: 0.32

Median Pre-Service Time: 2 Median Intra-Service Time: 2

25th Percentile Intra-Svc Time: 1 75th Percentile Intra-Svc Time: 3 Low: 1 High: 10

Median Post-Service Time: Total Time Number of Visits

Day of Procedure: 5

ICU: N/A

Other Hospital: N/A

Office: N/A

KEY REFERENCE SERVICE(S):

- | | <u>CPT Code</u> | <u>CPT Descriptor</u> | <u>RVW</u> |
|----|-----------------|--|------------|
| 1) | 99211 | Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services. | 0.17 |
| 2) | 11720 | Debridement of nail(s) by any method(s); one to five | 0.32 |

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

The total time for 117XX is slightly greater than the time for 99211, and about 50% of reference procedure 11720. 99211 may not require the presence of a physician. There is often slightly more mental effort and judgement, and psychological stress than 99211 because patients receiving 117XX are typically "at risk" patients.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
99211	1	5	1	1	1	1
11720	5	8	5	2	2	1

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? M0101

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period 200,000

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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April 17, 1997

Sherry L. Smith
American Medical Association
515 N. State Street
Chicago, IL 60610

Dear Sherry,

On behalf of the American Academy of Dermatology (AAD), American Society of Dermatologic Surgery (ASDS), Society of Investigative Dermatology (SID) we have reviewed the RUC Surveys submitted by the American Podiatric Medical Association on the revised Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus) code series, 110X1, 110X2 and 110X3. We would agree with the median values as APMA proposed.

Sincerely,

Thomas G. Olsen, M.D.
AAD RUC Advisorcc: Glenn Gastwirth, DPM, APMA Staff
John A. Zitelli, M.D., ASDS RUC Advisor
Curtis W. Hawkins, M.D., SID RUC Advisor
Diane Krier-Morrow, MBA, MPH, Staff, AAD/ASDS/SID

RUC HCPAC REVIEW BOARD
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Endoscopic Plantar Fasciotomy - Tab D

The Review Board reviewed a work rvu recommendation presented by Podiatry of 5.10 for a new code 29893 to describe Endoscopic plantar fasciotomy, which was based on a survey median of 37 podiatrists. The American Academy of Orthopaedic Surgeons provided a letter of support and stated that "the work of endoscopic plantar fasciotomy is extremely similar to reference procedure 28060 *Fasciectomy, excision of plantar fascia; partial* (work rvu = 5.05)." The Review Board expressed concern that this service is currently reported using code 28008 *Fasciotomy, foot and/or toe* which has an assigned work rvu of 4.19. The Review Board recommends 4.92 which represents the 25th percentile of the survey.

The Review Board also recommended that the current nomenclature for 28008 be reviewed and potentially changed to explain that this code is to be reported for superficial fascia versus the deep fascia described in this new code.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•29893	UU1	Endoscopic plantar fasciotomy	090	4.92

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

CPT Code: 2989X Tracking Number: UU1 Global Period: 90 Recommended RVW: 5.1

CPT Descriptor:

Endoscopic Plantar Fasciotomy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 43 year old female has an endoscopic plantar fasciotomy performed for recalcitrant heel pain. The patient has been managed conservatively for six months without any appreciable improvement.

Description of Pre-Service Work:

Review previous work-up, including consulting with referring physician, if necessary, and other health care professionals, such as the anesthesiologist; and communicating with the patient and/or the patient's family to explain the operative risks and benefits and to obtain informed consent. Other pre-operative services include scheduling the operation, dressing, scrubbing, and waiting to begin the operation; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary surgical instruments and supplies are present and available in the operative suite.

Description of Intra-Service Work:

Medial portal incision is marked on the patient corresponding to pre-operative mapping
6-7mm incision is made

Obturator/cannula is placed inferior to the plantar fascia

A small lateral incision is made to allow proper placement of obturator/cannula

Anatomical fascial landmarks are identified

Medial fascia incised

Fasciotomy is continued until two completely severed edges of fascia, separated by muscle belly, are identified on the video monitor

Foot is dorsiflexed to visualize fascial separation

Wound is flushed with sterile water through cannula

Obturator/cannula are removed

Incisions are sutured

Long acting local anesthetic and steroid are instilled into the wound

Compression dressing is applied

Description of Post-Service Work:

Monitoring the patient's stability in the recovery room; writing orders and dictating an operative summary; communicating with the family and other health care professionals (including written and oral reports and orders); fitting post-operative surgical shoe, writing and explaining home care instructions to patient and/or family; writing appropriate prescriptions for pain management; and writing discharge orders and summary. Additionally, the patient is typically seen in the office six times during the 90 day global period for removal of sutures; ordering and evaluating appropriate tests; further communication with referring physician; and pain management.

SURVEY DATA:Specialty: American Podiatric Medical AssociationSample Size: 37 Response Rate (%): 74 Median RVW: 5.125th Percentile RVW: 4.92 75th Percentile RVW: 5.25 Low: 4.85 High: 7.3Median Pre-Service Time: 60 Median Intra-Service Time: 3025th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 40 Low: 12 High: 60Median Post-Service Time: Total Time Number of VisitsDay of Procedure: 40ICU: N/AOther Hospital: N/AOffice: 75 6**KEY REFERENCE SERVICE(S):**

	CPT Code	CPT Descriptor	RVW
1)	28060	Fasciectomy, excision of plantar fascia; partial (separate procedure)	5.05
2)	28250	Division of plantar fascia and muscle ("Steindler stripping") (separate procedure)	5.66

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

2989X requires the same pre-service time as the key reference procedures. It requires the same intra-service time as 28060, but 50% less time than 28250. The reviewed procedure requires almost the same amount of post-service time as 28060, but 25 minutes less time than 28250. The median mental effort & judgement, and technical skill & physical effort for 2989X was higher than either of the two key reference procedures (4). The median psychological stress rating was the same for all three procedures.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psych Stress
28060	60	30	120	3	3	3
28250	60	45	145	3	3	3

CPT Code: 2989X

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? 28008, 28060-22, 28250

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 30,000-40,000

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

Insert in HCPAC Tab D



American Academy of Orthopaedic Surgeons

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April 21, 1997

Grant V. Rodkey, MD

Chairman, AMA/Specialty Society RVS Update Committee

Department of Payment Systems

American Medical Association

515 N. State Street

Chicago, IL 60610

Dear Dr. Rodkey:

On behalf of the American Academy of Orthopaedic Surgeons RVS Committee, I wish to offer comments on the physician work value recommendation for endoscopic plantar fasciotomy, developed by the American Podiatric Medical Association (APMA). This procedure is performed by some orthopaedic surgeons who specialize in foot and ankle surgery.

As indicated by the results of the APMA survey, the physician work of endoscopic plantar fasciotomy is extremely similar to that of the reference procedure 28060, Fasciectomy, excision of plantar fascia; partial. This is consistent with the Academy RVS Committee's recommendation of an RVW of 5.05.

However, it is the feeling of the Academy RVS Committee that reference procedure 28250, Division of plantar fascia and muscle, represents significantly greater technical skill, mental effort and judgment as compared to both 28060 and the surveyed procedure.

Sincerely,

Laura Lowe Tosi, MD

AAOS Representative

AMA/Specialty Society RVS Update Advisory Committee

RUC HCPAC REVIEW BOARD
SUMMARY OF RECOMMENDATIONS
APRIL 1997

Occupational and Physical Therapy Evaluation Services - Tab E

The CPT Editorial Panel recently added four new codes to describe physical therapy and occupational therapy evaluation services, which were cross-walked from existing HCPCS Level II codes. These HCPCS Level II codes were created by HCFA in 1993 and were assigned work rvus that were between level 2 (99202/99212) and level 3 (99203/99213) Evaluation and Management codes (or approximately 88% of 99203/99213). The American Physical Therapy Association (APTA) and the American Occupational Therapy Association (AOTA) presented recommendations based on the survey medians of more than 80 physical therapists and occupational therapists.

The Review Board did not accept these recommendations, but did agree that the work rvus for these services should be consistent with the initial relativity to the office visit Evaluation and Management codes. These recommendations are also at the 25th percentile of the APTA survey data.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•97001	AD1	Physical therapy evaluation	XXX	1.20
•97002	AD2	Physical therapy re-evaluation	XXX	0.60
•97003	AD3	Occupational therapy evaluation	XXX	1.20
•97004	AD4	Occupational therapy re-evaluation	XXX	0.60

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

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

CPT Code: 970X1 Tracking Number: AD1 Global Period: XXX Recommended RVW: 1.34

CPT Descriptor: Physical therapy evaluation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Typical Patient/Service: Initial visit with 56 year old female with right shoulder adhesive capsulitis. She has painful and limited range of motion with the inability to use the arm for the majority of her activities at work. Medical history is significant for hypertension. She has had shoulder complaints for less than one month. The examination includes but is not limited to:

- Range of Motion examination
- Joint integrity and mobility examination
- Muscle performance examination (including strength, power and endurance) left as compared to right
- Respiration, heart rate, blood pressure assessment

Environmental, home or work barriers examination

Description of Pre-Service Work:

Pre service work includes obtaining patient intake information, gathering or preparing equipment and materials that will be used during the procedure, and coordination or discussion with other team members.

Description of Intra-Service Work:

Intra service work includes:

- Examination of the patient to include obtaining a patient history, performing relevant systems reviews, and using tests and measures to elicit additional information.
- Evaluation of the patient based on data gathered from the examination, organizing and interpreting the data and establishing and/or obtaining such additional information as may be necessary.
- Development of a plan of care including prognosis for functional improvement and selection of interventions to produce improvement in the patient's condition.
- Education and instruction regarding the cause, prognosis and plan of care for the patient's condition which may include prevention and health promotion information.

Description of Post-Service Work:

Post service work includes documentation of the entire evaluation process (see intra service work) and the results of the evaluation as well as administration functions (such as patient and family communication, and scheduling) relative to the patient's care.

SURVEY DATA:Specialty: American Physical Therapy AssociationSample Size: 185 Response Rate (%): 28.1% Median RVW: 1.3425th Percentile RVW: 1.20 75th Percentile RVW: 1.40 Low: 0.75 High: 3.00
(next high 1.60)Median Pre-Service Time: 5 minutes Median Intra-Service Time: 30 minutes25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 45 Low: 20 High: 60Median Post-Service Time: 15 minutes

CPT Code: 970X1**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99203	Office or O/P visit, for E&M, new patient	1.34
2)	Q0103	Physical therapy evaluation	1.01
3)			
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
970X1	5	30	15	4	4	3
99203	5	30	15	4	4	3
Q0103	6	30	12.5	4	4	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? Q0103, 9920X series, numerous other variations

How often do physicians in your specialty perform this service? X Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period? > 1,000,000

Is this service performed by many physicians across the United States? X Yes No

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

CPT Code: 970X2_ Tracking Number: AD2 Global Period: XXX Recommended RVW: 0.67

CPT Descriptor: Physical therapy re-evaluation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Typical Patient/Service: Re-evaluation of an 18 year old female who had an ACL repair 8 weeks ago. She has been undergoing conservative management and is now at the appropriate stage for progression of an open and modified closed chain rehabilitation program. Joint effusion continues to be a problem with irritation from the prescribed brace patient is wearing. Examination would include but not be limited to the following:

- Range of motion examination
- Gait examination
- Joint integrity and mobility examination
- Girth measurement and muscle performance examination
- Functional Assessment

Description of Pre-Service Work:

Pre service work includes review of chart or history, gathering or preparing equipment or materials to be used during the procedure, and coordination with other team members.

Description of Intra-Service Work:

Intra service work includes:

- re-examination of the patient including verification of the patient history or chart, performing relevant system reviews, and using appropriate tests and measures of patient progress.
- re-evaluation of the patient based on the data gathered in the re examination, and organizing and interpreting the data and establishing and obtaining such additional information as may be necessary.
- modification of the plan of care as appropriate to the results of the re evaluation.
- education and instruction as appropriate to the results of the re evaluation.

Description of Post-Service Work:

Post service work includes documentation of the entire evaluation process (see intra service work) and the results of the evaluation as well as administration functions (such as patient and family communication, and scheduling) relative to the patient's care.

SURVEY DATA:Specialty: American Physical Therapy AssociationSample Size: 185 Response Rate (%): 27.6% Median RVW: 0.6725th Percentile RVW: 0.60 75th Percentile RVW: 0.80 Low: 0.48 High: 1.50Median Pre-Service Time: 5 minutes Median Intra-Service Time: 20 minutes25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 25 Low: 10 High: 45Median Post-Service Time: 10 minutes

CPT Code: 970X2**KEY REFERENCE SERVICE(S):**

	<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
1)	99213	Office or O/P visit, for E&M, established	0.67
2)	Q0104	Physical therapy re-evaluation	0.50
3)			
4)			

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
970X2	5	20	10	4	4	3
99213	5	15	10	4	4	3
Q0104	5	20	10	4	4	3

ADDITIONAL RATIONALE

For example, if recommended RVUs are based on an alternative method instead of the survey results.

FREQUENCY INFORMATION

How was this service previously reported? Q0104, 9921X series, numerous other variations

How often do physicians in your specialty perform this service? X Commonly Sometimes Rarely

Estimate the number of times this service might be provided nationally in a one-year period? > 1,000,000

Is this service performed by many physicians across the United States? X Yes No

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**CPT Code: 970X3 Tracking Number: AD3 Global Period: XXX Recommended Work RVU: 1.34CPT Descriptor: Occupational Therapy Evaluation**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Initial visit with a 42 year old female with diagnosis of multiple sclerosis. Patient is employed as a librarian. She shares in care giver responsibilities of her two teenage children and in home maintenance tasks. Her chief complaints are lack of strength and endurance and sensory problems. The therapist designs an activity which parallels the physical requirements of the activities in which the patient has identified deficits. In addition to observing the patient's completion of the activity, the therapist engages the patient in a discussion of other issues that the patient believes are interfering with her ability to function in her home and career. Based on the patient's self report and actual performance, the patient's deficits in the following performance components (see Uniform Terminology for Occupational Therapy, 3rd edition) are evaluated:

- activities of daily living
- work and productive activities
- sensory awareness
- sensory processing
- neuro-musculoskeletal (e.g., range of motion, muscle tone, endurance, strength)
- motor (e.g., gross coordination, bilateral integration, fine coordination, visual-motor integration)

Description of Pre-Service Work:

Clarify referral, if necessary

Review records forwarded with referral

Discuss patient status with relevant health care professionals, if needed

Description of Intra-Service Work:

Interview patient, family, caregiver to establish patient goals

Take functional history

Perform evaluation:

- Apply specific assessments/tests/measurements/adaptations
- Observe patient performing activities
- Assess components (e.g., sensory processing, neuro-musculoskeletal, motor)
- Assess contextual factors affecting patients performance
- Develop care plan
- Determine possible goals/outcomes

Discuss treatment options and functional prognosis with patient/family

Description of Post-Service Work:

Write evaluation documenting occupational therapy diagnosis

Complete documentation of intervention plan and treatment/goals

Access community resources, if appropriate

SURVEY DATA:Specialty: AOTASample Size: 181 Response Rate (%): 18.7% (34) Median RVU: 1.4025th Percentile RVU: 1.30 75th Percentile RVU: 1.50 Low: 0.79 High: 3.58Median Pre-Service Time: 15 Median Intra-Service Time: 4525th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 60 Low: 10 High: 100Median Post-Service Time: 15

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Work RVU</u>
1) 99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: <ul style="list-style-type: none"> • a detailed history; • a detailed examination; and • medical decision making of low complexity Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.	1.34
2) 92525	Evaluation of swallowing and oral function for feeding	1.50

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
99203	7	30	10	3	3	3
92525	10	30	15	5	4	3
970X3	10	45	15	4	4	3

ADDITIONAL RATIONALE

We are recommending the median value calculated after outliers are removed.

When the obvious outliers (3) are removed, the summary data statistics are as follows:

Median RVW 1.34 25th Percentile RVW: 1.25

FREQUENCY INFORMATION

How was this service previously reported? 00109, 99203, 99204

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 500,000+

Is this service performed by many physicians across the United States? ☒ Yes ☐ No

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

CPT Code: 970X4 Tracking Number: AD4 Global Period: XXX Recommended Work RVU: 0.85

CPT Descriptor: Occupational therapy re-evaluation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Patient is 49 year old female who sustained a forearm fracture (distal end of the radius) in an automobile accident. She received treatment during and after casting to prevent edema, maintain range of motion, muscle strength and sensation, and assure safe return to daily activities. She was discharged to home 3 months ago with a maintenance program of exercises and gradual increase in daily home activities. She returned to work 6 weeks ago. During a recent physician visit, she complained that her ability to grasp and hold objects had not returned to normal and there was pain and a lack of strength associated with these activities. She was referred back to therapy, as these problems are interfering with her ability to get dressed, prepare meals and perform her job as a manicurist. The therapist re-assesses her ability to perform tasks with the affected arm and re-tests muscle strength, using discharge data as a baseline, and explores compensatory methods which help to ameliorate the pain. Based on the patient's self report and actual performance, the patient's deficits in the following performance components (see Uniform Terminology for Occupational Therapy, 3rd edition) are re-evaluated:

- activities of daily living
- work and productive activities
- neuro-musculoskeletal
- motor

Description of Pre-Service Work:

Review chart/history

Communicate with physician and/or other relevant health care professionals on patient status/progress

Gather/prepare materials to be used in reevaluation

Description of Intra-Service Work:

Discuss patient's complaint and desired goals and outcomes

Re-examine functional performance

- Observe patient perform activities
- Reassess performance components through specific assessments

Re-educate/train on home program, equipment, as needed

Discuss treatment options

Description of Post-Service Work:

Write documentation of re-evaluation

Communicate with physician and relevant health care professionals, as appropriate

SURVEY DATA:

Specialty: AOTA

Sample Size: 181 Response Rate (%): 19.3% (35) Median RVU: 0.85

25th Percentile RVU: 0.76 75th Percentile RVU: 1.11 Low: 0.57 High: 3.50

Median Pre-Service Time: 15 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 30 75th Percentile Intra-Svc Time: 45 Low: 10 High: 100

Median Post-Service Time: 15

KEY REFERENCE SERVICE(S):

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Work RVU</u>
1) 99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: <ul style="list-style-type: none"> • an expanded problem focused history; • an expanded problem focused examination; and • straightforward medical decision making of low complexity Usually, the presenting problems(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.	0.67
2) 97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes	0.45

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

Compare the pre-, intra-, and post-service time and the intensity (mental effort and judgement; technical skill & physical effort; and psychological stress) of the service you are rating to the key reference services listed above.

CPT Code	Median Pre-Time	Median Intra-Time	Median Post-Time	Median Mental Effort & Judgement	Median Technical Skill & Physical Effort	Median Psychological Stress
99213	10	15	15	3	3.5	3
97750	10	30	10	4	4	1
970X4	10	30	15	4	4	3

The respondents believe that the average OT evaluation/re-evaluation is always longer than a physician re-evaluation due to the environmental and contextual elements that are addressed.

ADDITIONAL RATIONALE

When the obvious outliers (3) are removed, the survey data statistics are as follows:

Median RVW: 0.85 25th Percentile RVW: 0.75

FREQUENCY INFORMATION

How was this service previously reported? Q0110.99213.99214

How often do physicians in your specialty perform this service? ☒ Commonly ☐ Sometimes ☐ Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 300,000+

Is this service performed by many physicians across the United States? ☒ Yes ☐ No