

# RUC Recommendations

For CPT 2004

*RUC Meetings:  
September 2002, February 2003 and  
April 2003*

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
RUC RECOMMENDATIONS FOR CPT 2004**

**TABLE OF CONTENTS**

Anesthesia Services: Mediastinoscopy and Diagnostic Thorascopy	1
Anesthesia for Pelvic Acetabular Fracture	2
Anesthesia for External Cephalic Version Procedure	3
Hyoid Myomectomy and Suspension	4
Lateral Extracavitary Approach Technique/Vertebral Corpectomy and Arthrodesis	5
Transbronchial Biopsy Procedures	6
Exploratory Cardiotomy Codes	7
Endovascular Repair of Abdominal Aortic Aneurysm	8
Upper Extremity Bypass Graft	9
Re-implantation of Visceral Artery	10
Central Venous Access Device	11
Distal Revascularization and Interval Ligation	12
Varicose Vein Stab Phlebectomy	13
Bone Marrow Procedures	14
Esophagogastroduodenoscopy with Ultrasound Examination	15
Naso- or Oro-gastric Tube Placement	16
Living Donor Hepatectomies	17
Urethrolisis	18
Laposcopic Colpopexy	19
Intrauterine Fetal Surgical Procedures	20

Limited Temporal Lobe Resection and Lobectomy without Corticography	21
Deep Brian Stimulation	22
Lumbar and Superior Hypogastric Plexus Injection and Destruction	23
Amniotic Membrane Transplant	24
Upper Eyelid Load Implantation	25
Intraoperative MRI	26
Corneal Pachymetry Echography	27
Multiple Day Nuclear Medicine Whole Body Spect Imaging	28
Radiolabled Monoclonal Antibody Infusion	29
Comprehensive Coagulation Assessment	30
Cytopathology, Selective Cellular Enhancement Technique	31
Tumor Morphometry	A
Capsule Tract Imaging	B
Refilling of Implantable Pumps	C

# American Medical Association

Physicians dedicated to the health of America



**James G. Hoehn, MD**      515 North State Street      312 464-5604  
Chairman                      Chicago, Illinois 60610      312 464-5849 Fax  
AMA/Specialty Society RVS  
Update Committee

May 29, 2003

Terry Kay  
Center for Health Plans and Providers  
Health Care Financing Administration  
7500 Security Boulevard, C4-01-15  
Baltimore, Maryland 21244

Dear Mr. Kay:

It is with pleasure that I submit to the Centers for Medicare and Medicaid Services (CMS), on behalf of the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC), work relative value and direct practice expense inputs for new and revised codes for CPT 2004. Also included in this submission are the practice expense refinement recommendations for existing CPT 2003 codes; work relative value practice expense recommendations for a few remaining interim values for CPT 2003; and work relative value recommendations for codes that you had specifically requested the RUC to review. The RUC Health Care Professionals Advisory Committee (HCPAC) Review Board are separately forwarding their recommendations to you, as well.

## CPT 2004 New and Revised Codes

Enclosed is one binder of RUC recommendations for new and revised codes. The total number of coding changes for CPT 2004 is 272, including 135 additions, 91 revisions, and 46 deletions. Sixty-two of these coding changes are not payable on the RBRVS (eg, laboratory services, vaccines, and services paid through the home health agency payment system), and accordingly, the RUC does not submit any information on these codes. In addition, two of the new and revised codes were reviewed by the RUC HCPAC Review Board as they describe services provided by non-MD/DO health professionals. Of the remaining 162 new and revised codes, the RUC submits 159 recommendations at this time.

The RUC is recommending that five codes, describing hyoid myomectomy (21685) and intrauterine fetal surgical procedures (59070-59076) be carrier-priced in 2004, until the RUC has further opportunity to review data for these services. The RUC will not be submitting relative value recommendations for three services recently revised at the May 2003 CPT Editorial Panel meeting, including: percutaneous radio frequency ablation of bone tumor lesions (20982) and computer aided detection for mammography (76082 and 76083). The summary table in the attached binder, and in the enclosed diskette, specifically identifies the services to be reviewed at the September 2003 RUC meeting. We will send any new information to CMS immediately following the meeting.

Terry Kay  
May 29, 2003  
Page Two

Also included in this binder, and on the enclosed diskette, is physician time data for each of the CPT codes reviewed at the September 2002, February 2003, and April 2003 RUC meetings. We will be sending you a comprehensive revision to the entire RUC database for physician time by June 30. The RUC also recommends that CMS revise its database of physician time prior to the 2004 Physician Payment Schedule publication to consistently reflect discharge day visits and time for services typically performed in the facility setting. The RUC continues to review the physician time data to ensure that the most accurate data is utilized in the CMS practice expense methodology.

#### Practice Expense Refinements

Also enclosed in this submission is one binder and CD-ROM of practice expense refinement recommendations to existing codes resulting from the tremendous efforts of the RUC's Practice Expense Advisory Committee (PEAC) over the past year. The RUC is submitting recommendations on the direct practice expense inputs for nearly 1,200 existing CPT codes. Included in these recommendations are the PEAC refinements for the remaining Evaluation and Management Services. CMS had requested that we conduct this review in time for the 2004 Physician Payment Schedule. The PEAC will continue its efforts in the next year with review of all of the radiology services and other remaining refinement issues.

#### CPT 2003 Interim Values

Immediately following our September 2002 and February 2003 meetings, we submitted further recommendations on codes that were new and revised for CPT 2003. We have included this material again in this submission and ask that you consider this information as you review the 2003 interim values over this summer. These recommendations include comment on the following issues:

- Mohs Surgery
- Bone Marrow Procedures
- Excision of Mandible Facial Bone Tumor
- Laparoscopic Hysterectomy Myomectomy
- Minimally Invasive Repair of Pectus Excavatum
- Refilling of Implantable Pumps
- Therapeutic Apheresis

#### Special CMS Requests

Finally, we are also submitting our response to issues that CMS had asked the RUC to review. During the second, Five-Year Review of the RBRVS, CMS had requested that the RUC

Terry Kay  
May 29, 2003  
Page Three

review the family of codes related to Central Nervous System Assessment/Tests (CPT codes 96100-96117). Two of these services (developmental testing, codes 96110 and 96111) have been surveyed by specialty societies representing MDs and have been reviewed by the RUC. The RUC has completed its review of both the work and direct practice expense for developmental testing and these recommendations are included in our submission. The RUC HCPAC Review Board continues to review the remaining services in this family (CPT codes 96100, 96105, 96115, and 96117) and will submit recommendations for these codes in the future.

On a personal note, I would like to thank you for the quality staff that you have assigned to participate in our meetings. I have enjoyed working with Paul, Ken, Rick, Marc, Carolyn, and Pam during my tenure as Chairman of the RUC. We also appreciated the visit by Tom Scully, Doctor Hambrick and Doctor Bowman at our last meeting and welcome them, and any other CMS staff, back at anytime. Doctor William Rich has been appointed as the new Chairman of the RUC. His term begins on June 1, immediately following this submission of these recommendations. I'm sure that he will enjoy the collegial relationships with CMS representatives as much as I have.

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

Sincerely,



James G. Hoehn, MD

cc: William Rich, MD  
Paul Rudolf, MD  
Ken Simon, MD  
Rick Ensor  
Marc Hartstein  
Carolyn Mullen  
Pam West, PT  
Sherry Smith  
Patrick Gallagher

# CPT 2004 RUC Recommendations

CPT Code	Global	Coding Period	CPT Change	CPT Date	Issue Tab	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
00528	XXX	R	Nov02	J	Anesthesia Services Mediastinoscopy and Diagnostic Thorascopy	G1	Feb03	7	ASA		8.00	8.00	Yes	Yes	
00529	XXX	N	Nov02	J	Anesthesia Services Mediastinoscopy and Diagnostic Thorascopy	G2	Feb03	7	ASA		11.00	11.00		Yes	
00544	XXX	D	Nov02	I	Anesthesia Procedures for Pleurectomy				Deleted					Yes	
01173	XXX	N	Feb03	E	Anesthesia for Acetabular Fracture	S1	Apr03	6	ASA		12.00	12.00		Yes	
01958	XXX	N	Nov02	L	Anesthesia for External Cephalic Version Procedure	H1	Feb03	8	ASA		5.00	5.00		Yes	
11100	000	R	Aug02	K	Skin Biopsy				Editorial		0.81	0.81	Yes	Yes	
11101	ZZZ	R	Aug02	K	Skin Biopsy				Editorial		0.41	0.41	Yes	Yes	
20240	010	R	May03	Q	Musculoskeletal Section Editorial Revision				Editorial		3.23	3.23	Yes	Yes	
20550	000	R	Nov02	N	Plantar Fascia Injection/Injection of Trigger Points				Editorial		0.75	0.75	Yes	Yes	
20551	000	R	Nov02	N	Plantar Fascia Injection/Injection of Trigger Points				Editorial		0.75	0.75	Yes	Yes	
20552	000	R	Nov02	N	Plantar Fascia Injection/Injection of Trigger Points				Editorial		0.66	0.66	Yes	Yes	
20982		N	May03	EC19	Percutaneous RF Ablation of Bone Tumor Lesions		Sept03							Yes	To be submitted after Sept 2003 RUC Meeting



CPT Code	Global Coding Period	Coding Change	CPT Date	CPT Issue Tab	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
31630	000	R	Nov02	D	Transbronchial Biopsy Procedures		Apr03	8	ACCP/ATS	3.82	<b>3.82</b>	Yes	Yes	
31631	000	R	Nov02	D	Transbronchial Biopsy Procedures		Apr03	8	ACCP/ATS	4.37	<b>4.37</b>	Yes	Yes	
31632	ZZZ	N	Nov02	D	Transbronchial Biopsy Procedures	K4	Apr03	8	ACCP/ATS	1.03	<b>1.03</b>		Yes	
31633	ZZZ	N	Nov02	D	Transbronchial Biopsy Procedures	K5	Apr03	8	ACCP/ATS	1.32	<b>1.32</b>		Yes	
31635	000	R	Nov02	D	Transbronchial Biopsy Procedures		Apr03	8	ACCP/ATS	3.68	<b>3.68</b>	Yes	Yes	
31640	000	R	Nov02	D	Transbronchial Biopsy Procedures		Apr03	8	ACCP/ATS	4.94	<b>4.94</b>	Yes	Yes	
33310	090	R	Feb03	9	Exploratory Cardiotomy Codes	U1	Apr03	9	STS	18.51	<b>18.51</b>	Yes	Yes	
33315	090	R	Feb03	9	Exploratory Cardiotomy Codes	U2	Apr03	9	STS	22.37	<b>22.37</b>	Yes	Yes	
34805	090	N	Feb03	1A	Endovascular Repair of Abdominal Aortic Aneurysm	V1	Apr03	10	AAVS/SVS, ACR	21.88	<b>21.88</b>		Yes	
35510	090	N	Feb03	Q	Upper Extremity Bypass Graft	W1	Apr03	11	AAVS/SVS	23.00	<b>23.00</b>		Yes	
35512	090	N	Feb03	Q	Upper Extremity Bypass Graft	W2	Apr03	11	AAVS/SVS	22.50	<b>22.50</b>		Yes	
35522	090	N	Feb03	Q	Upper Extremity Bypass Graft	W3	Apr03	11	AAVS/SVS	21.76	<b>21.76</b>		Yes	
35525	090	N	Feb03	Q	Upper Extremity Bypass Graft	W4	Apr03	11	AAVS/SVS	20.63	<b>20.63</b>		Yes	

CPT Code	Global Coding Period	CPT Change	CPT Date	CPT Issue Tab	Tracking Number	RUC Date	RUC S.S. Tab	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
35697	ZZZ	N	Feb03	R	Re-implantation of Visceral Artery	M1	Apr03	12 AAVS/ SVS	4.25	3.00			Yes
36400	XXX	R	Aug02	L	Pediatric Venipuncture		Editorial		0.38	0.38	Yes		Yes
36405	XXX	R	Aug02	L	Pediatric Venipuncture		Editorial		0.31	0.31	Yes		Yes
36406	XXX	R	Aug02	L	Pediatric Venipuncture		Editorial		0.18	0.18	Yes		Yes
36410	XXX	R	Aug02	L	Pediatric Venipuncture		Editorial		0.18	0.18	Yes		Yes
36488	000	D	Feb03	IJ	Central Venous Access Device		Deleted						Yes
36489	000	D	Feb03	IJ	Central Venous Access Device		Deleted						Yes
36490	000	D	Feb03	IJ	Central Venous Access Device		Deleted						Yes
36491	000	D	Feb03	IJ	Central Venous Access Device		Deleted						Yes
36493	000	D	Feb03	IJ	Central Venous Access Device		Deleted						Yes
36530	010	D	Feb03	IJ	Central Venous Access Device		Deleted						Yes
36531	010	D	Feb03	IJ	Central Venous Access Device		Deleted						Yes
36532	010	D	Feb03	IJ	Central Venous Access Device		Deleted						Yes
36533	010	D	Feb03	IJ	Central Venous Access Device		Deleted						Yes
36534	010	D	Feb03	IJ	Central Venous Access Device		Deleted						Yes
36535	010	D	Feb03	IJ	Central Venous Access Device		Deleted						Yes
36536	000	D	Feb03	IJ	Central Venous Access Device		Deleted						Yes
36537	000	D	Feb03	IJ	Central Venous Access Device		Deleted						Yes

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
36555	000	N	Feb03	IJ	Central Venous Access Device	L1	Apr03	13	ACR, ASA, SIR		2.68	2.68		Yes	
36556	000	N	Feb03	IJ	Central Venous Access Device	L2	Apr03	13	ACR, ASA, SIR		2.50	2.50		Yes	
36557	010	N	Feb03	IJ	Central Venous Access Device	L3	Apr03	13	ACR, ACS, APSA, SIR		5.10	5.10		Yes	
36558	010	N	Feb03	IJ	Central Venous Access Device	L4	Apr03	13	ACR, ACS, APSA, SIR		4.80	4.80		Yes	
36560	010	N	Feb03	IJ	Central Venous Access Device	L5	Apr03	13	ACR, ACS, APSA, SIR		6.25	6.25		Yes	
36561	010	N	Feb03	IJ	Central Venous Access Device	L6	Apr03	13	ACR, ACS, APSA, SIR		6.00	6.00		Yes	
36563	010	N	Feb03	IJ	Central Venous Access Device	L7	Apr03	13	ACR, ACS, APSA, SIR		6.20	6.20		Yes	
36565	010	N	Feb03	IJ	Central Venous Access Device	L8	Apr03	13	ACR, ACS, APSA, SIR		6.00	6.00		Yes	

CPT Code	Global Coding Period	Coding Change	CPT Date	CPT Issue Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
36566	010	N	Feb03	IJ	Central Venous Access Device	L9	Apr03	13	ACR, ACS, APSA, SIR		6.50	6.50		Yes	
36568	000	N	Feb03	IJ	Central Venous Access Device	L10	Apr03	13	ACR, ACS, APSA, SIR		1.92	1.92		Yes	
36569	000	N	Feb03	IJ	Central Venous Access Device	L11	Apr03	13	ACR, ACS, APSA, SIR		1.82	1.82		Yes	
36570	010	N	Feb03	IJ	Central Venous Access Device	L12	Apr03	13	ACR, ACS, APSA, SIR		5.32	5.32		Yes	
36571	010	N	Feb03	IJ	Central Venous Access Device	L13	Apr03	13	ACR, ACS, APSA, SIR		5.30	5.30		Yes	
36575	000	N	Feb03	IJ	Central Venous Access Device	L14	Apr03	13	ACR, SIR		0.67	0.67		Yes	
36576	010	N	Feb03	IJ	Central Venous Access Device	L15	Apr03	13	ACR, SIR		3.19	3.19		Yes	
36578	010	N	Feb03	IJ	Central Venous Access Device	L16	Apr03	13	ACR, SIR		3.50	3.50		Yes	



CPT Code	Global Coding Period	CPT Change	CPT Date	CPT Issue Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
36597	000	N	May03	EC28	Central Venous Access Device	L29	Apr03	13	ACR, SIR		1.21	1.21		Yes	Renumbered Code from 36493
36838	090	N	Feb03	P	Distal Revascularization and Interval Ligation	Y1	Apr03	14	AAVS/ SVS		20.63	20.63		Yes	
37765	090	N	Feb03	S	Varicose Vein Stab Phlebectomy	Z1	Apr03	15	AAVS/ SVS		7.35	7.35		Yes	
37766	090	N	Feb03	S	Varicose Vein Stab Phlebectomy	Z2	Apr03	15	AAVS/ SVS		9.30	9.30		Yes	
37785	090	R	Feb03	S	Varicose Vein Stab Phlebectomy	Z3	Apr03	15	AAVS/ SVS		3.84	3.84	yes	Yes	
38208	XXX	R	Nov02	EC24	Bone Marrow Procedures	X4	Apr03	16	ASH		0.56	0.56		Yes	Interim
38209	XXX	R	Nov02	EC24	Bone Marrow Procedures	X5	Apr03	16	ASH		0.24	0.24		Yes	Interim. Will need to be re-examined due to code revision
43235	000	R	Feb03	V	Esophagogastroduodenoscopy with Ultrasound Examination		Apr03	17	AGA, ASGE		2.39	2.39	Yes	Yes	
43237	000	N	Feb03	V	Esophagogastroduodenoscopy with Ultrasound Examination	AA1	Apr03	17	AGA, ASGE		3.99	3.99		Yes	
43238	000	N	Feb03	V	Esophagogastroduodenoscopy with Ultrasound Examination	AA2	Apr03	17	AGA, ASGE		5.03	5.03		Yes	
43242	000	R	Feb03	V	Esophagogastroduodenoscopy with Ultrasound Examination	AA3	Apr03	17	AGA, ASGE		7.31	7.31	yes	Yes	
43259	000	R	Feb03	V	Esophagogastroduodenoscopy with Ultrasound Examination	AA4	Apr03	17	AGA, ASGE		5.20	5.20		Yes	

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
43752	XXX	R	Feb03	EC-X	Naso- or Oro-gastric Tube Placement	D1	Feb03	13	ACR, ACS		0.82	0.82		Yes	
47133	XXX	R	Feb03	W	Living Donor Hepatectomies	BB1	Apr03	18	ACS					Yes	Carrier Price
47134	XXX	D	Feb03	W	Living Donor Hepatectomies		Deleted	18	ACS					Yes	
47140	090	N	Feb03	W	Living Donor Hepatectomies	BB2	Apr03	18	ACS		55.00	55.00		Yes	
47141	090	N	Feb03	W	Living Donor Hepatectomies	BB3	Apr03	18	ACS		67.50	67.50		Yes	
47142	090	N	Feb03	W	Living Donor Hepatectomies	BB4	Apr02	18	ACS		75.00	75.00		Yes	
53500	090	N	May02	J	Urethrolisis	A1	Sept02	12	AUA		12.21	12.21		Yes	
57425	090	N	Feb03	Y	Laposcopic Colpopexy	CC1	Apr03	19	ACOG		15.75	15.75		Yes	
58340	XXX	R	Nov02	V	Radiology Editorial Revisions		Editorial				0.88	0.88	Yes	Yes	
59070	000	N	Feb03	Z	Intrauterine Fetal Surgical Procedures	DD4	Apr03	20	ACOG, ASPS					Yes	Carrier Price RUC to review in September 2003
59072	000	N	Feb03	Z	Intrauterine Fetal Surgical Procedures	DD2	Apr03	20	ACOG, APSA					Yes	Carrier Price RUC to review in September 2003
59074	000	N	Feb03	Z	Intrauterine Fetal Surgical Procedures	DD3	Apr03	20	ACOG, ASPS					Yes	Carrier Price. RUC to review in September 2003
59076	000	N	Feb03	Z	Intrauterine Fetal Surgical Procedures	DD1	Apr03	20	ACOG, APSA					Yes	Carrier Price RUC to review in September 2003

CPT Code	Global Coding	CPT Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
59897	YYY	N	Feb03	Z	Intrauterine Fetal Surgical Procedures	DD5	Apr03	20	ACOG, ASPS					Yes	Carrier Price RUC to review in September 2003.
61537	090	N	Nov02	S	Limited Temporal Lobe Resection and Lobectomy without Corticography	N1	Apr03	21	AANS/CNS	25.00	25.00			Yes	
61538	090	R	Nov02	S	Limited Temporal Lobe Resection and Lobectomy without Corticography		Apr03	21	AANS/CNS	26.81	26.81	Yes		Yes	
61539	090	R	Nov02	S	Limited Temporal Lobe Resection and Lobectomy without Corticography		Apr03	21	AANS/CNS	32.08	32.08	Yes		Yes	
61540	090	N	Nov02	S	Limited Temporal Lobe Resection and Lobectomy without Corticography	N2	Apr03	21	AANS/CNS	30.00	30.00			Yes	
61543	090	R	Nov02	S	Limited Temporal Lobe Resection and Lobectomy without Corticography		Apr03	21	AANS/CNS	29.22	29.22	Yes		Yes	
61566	090	N	Nov02	S	Limited Temporal Lobe Resection and Lobectomy without Corticography	N3	Apr03	21	AANS/CNS	31.00	31.00			Yes	
61567	090	N	Nov02	S	Limited Temporal Lobe Resection and Lobectomy without Corticography	N4	Apr03	21	AANS/CNS	35.50	35.50			Yes	
61862	090	D	Feb03	1	Deep Brain Stimulation		Apr03	22	AANS/CNS					Yes	
61863	090	N	Feb03	1	Deep Brain Stimulation	EE1	Apr03	22	AANS/CNS	19.00	19.00			Yes	
61864	ZZZ	N	Feb03	1	Deep Brain Stimulation	EE2	Apr03	22	AANS/CNS	4.50	4.50			Yes	

CPT Code	Global Coding Period	CPT Change	CPT Date	CPT Issue Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
61867	090	N	Feb03	1	Deep Brain Stimulation	EE3	Apr03	22	AANS/ CNS		33.00	<b>31.34</b>		Yes	
61868	ZZZ	N	Feb03	1	Deep Brain Stimulation	EE4	Apr03	22	AANS/ CNS		8.00	<b>7.92</b>		Yes	
63101	090	N	Nov02	T	Lateral Extracavitary Technique Vertebral Corpectomy and Arthrodesis	J4	Feb03	11	AANS/ CNS		32.00	<b>32.00</b>		Yes	
63102	090	N	Nov02	T	Lateral Extracavitary Technique Vertebral Corpectomy and Arthrodesis	J5	Feb03	11	AANS/ CNS		32.00	<b>32.00</b>		Yes	
63103	ZZZ	N	Nov02	T	Lateral Extracavitary Technique Vertebral Corpectomy and Arthrodesis	J6	Feb03	11	AANS/ CNS		5.00	<b>5.00</b>		Yes	
63173	090	R	Aug02	O	Laminectomy Drainage to Pleural Space (Revision to 63173)		Editorial				21.99	<b>21.99</b>	Yes	Yes	
64449	010	N	Feb03	2	Lumbar and Superior Hypogastric Plexus Injection and Destruction	FF1	Apr03	23	AAPM, ASA		3.15	<b>3.00</b>		Yes	
64517	000	N	Feb03	2	Lumbar and Superior Hypogastric Plexus Injection and Destruction	FF2	Apr03	23	AAPM, ASA		2.20	<b>2.20</b>		Yes	
64680	010	R	Feb03	2	Lumbar and Superior Hypogastric Plexus Injection and Destruction		Apr03	23	AAPM, ASA		2.62	<b>2.62</b>	Yes	Yes	
64681	010	N	Feb03	2	Lumbar and Superior Hypogastric Plexus Injection and Destruction	FF3	Apr03	23	AAPM, ASA		3.55	<b>3.55</b>		Yes	
65780	090	N	Nov02	U	Amniotic Membrane Transplant	O1	Feb03	15	AAO, CLSA		10.25	<b>10.25</b>		Yes	
65781	090	N	Nov02	U	Amniotic Membrane Transplant	O2	Feb03	15	AAO, CLSA		17.67	<b>17.67</b>		Yes	
65782	090	N	Nov02	U	Amniotic Membrane Transplant	O3	Feb03	15	AAO, CLSA		15.00	<b>15.00</b>		Yes	

CPT Code	Global Coding Period	CPT Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
67912	090	N	Feb03	3	Upper Eyelid Load Implantation	GG1	Apr03	24	AAO		6.75	5.68			Yes
67916	090	R	Aug02	P	Blepharosplasty		Editorial				5.31	5.31	Yes		Yes
67917	090	R	Aug02	P	Blepharosplasty		Editorial				6.02	6.02	Yes		Yes
67923	090	R	Aug02	P	Blepharosplasty		Editorial				5.88	5.88	Yes		Yes
67924	090	R	Aug02	P	Blepharosplasty		Editorial				5.79	5.79	Yes		Yes
68371	010	N	Nov02	U	Amniotic Membrane Transplant	O4	Feb03	15	AAO,C LSA		4.90	4.90			Yes
70250	XXX	R	Nov02	V	Radiology Editorial Revisions		Editorial				0.24	0.24	Yes		Yes
70260	XXX	R	Nov02	V	Radiology Editorial Revisions		Editorial				0.34	0.34	Yes		Yes
70557	XXX	N	Nov02	6	Intraoperative MRI	P1	Apr03	26	AANS/ CNS, ACR, ASNR		3.20	2.90			Yes
70558	XXX	N	Nov02	6	Intraoperative MRI	P2	Apr03	26	AANS/ CNS, ACR, ASNR		3.20	3.20			Yes
70559	XXX	N	Nov02	6	Intraoperative MRI	P3	Apr03	26	AANS/ CNS, ACR, ASNR		3.20	3.20			Yes
72270	XXX	R	Nov02	V	Radiology Editorial Revisions		Editorial				1.33	1.33	Yes		Yes
75860	XXX	R	May03	EC20	Venography		Editorial				1.14	1.14	Yes		Yes
75901	XXX	R	Feb03	IJ	Central Venous Access Device		Apr03	13	ACR, SIR		0.49	0.49	Yes		Yes

CPT Code	Global Coding Change	CPT Period	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
75902	XXX	R	Feb03	IJ	Central Venous Access Device		Apr03	13	ACR, SIR		0.39	0.39	Yes	Yes	
75998	ZZZ	N	Feb03	IJ	Central Venous Access Device	L27	Apr03	13	ACR, SIR		0.38	0.38		Yes	
76082	XXX	N	May03	EC29	Computer Aided Detection Diagnostic Mammography	OO1	Sept03							Yes	To be submitted after Sept 2003 RUC Meeting
76083	XXX	N	May03	EC29	Computer Aided Detection Diagnostic Mammography	OO2	Sept03							Yes	To be submitted after Sept 2003 RUC Meeting
76085	XXX	D	May03	EC29	Computer Aided Detection Diagnostic Mammography		Deleted							Yes	
76362	XXX	R	Feb03	L	Radiology Editorial Revisions		Editorial				4.00	4.00	Yes	Yes	
76375	XXX	R	Feb03	L	Radiology Editorial Revisions		Editorial				0.16	0.16	Yes	Yes	
76394	XXX	R	Feb03	L	Radiology Editorial Revisions		Editorial				4.25	4.25	Yes	Yes	
76490	XXX	D	May03	EC29	Computer Aided Detection Diagnostic Mammography		Deleted							Yes	
76514	XXX	N	Feb02	1C	Corneal Pachymetry Echography	HH1	Apr03	25	AAO		0.17	0.17		Yes	
76831	XXX	R	Nov02	V	Radiology Editorial Revisions		Editorial				0.72	0.72	Yes	Yes	
76872	XXX	R	Nov02	V	Radiology Editorial Revisions		Editorial				0.69	0.69	Yes	Yes	
76937	ZZZ	N	Feb03	IJ	Central Venous Access Device	L28	Apr03	13	ACR, SIR		0.30	0.30		Yes	
76940	XXX	N	Nov02	V	Radiology Editorial Revisions		Editorial				2.00	2.00		Yes	Renumbered code from 76490

CPT Code	Global Coding	CPT Change	CPT Date	CPT Issue Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
78800	XXX	R	Feb03	10	Multiple Day Nuclear Medicine Whole Body Spect Imaging		Apr03	27	ACR, SNM		0.66	0.66	Yes	Yes	
78801	XXX	R	Feb03	10	Multiple Day Nuclear Medicine Whole Body Spect Imaging		Apr03	27	ACR, SNM		0.79	0.79	Yes	Yes	
78802	XXX	R	Feb03	10	Multiple Day Nuclear Medicine Whole Body Spect Imaging	II1	Apr03	27	ACR, SNM		0.86	0.86	Yes	Yes	
<del>78803</del>	<del>XXX</del>	<del>R</del>	<del>Feb03</del>	<del>10</del>	<del>Multiple Day Nuclear Medicine Whole Body Spect Imaging</del>		<del>Apr03</del>	<del>27</del>	<del>ACR, SNM</del>		<del>1.09</del>	<del>1.09</del>	<del>Yes</del>	<del>Yes</del>	
78804	XXX	N	Feb03	10	Multiple Day Nuclear Medicine Whole Body Spect Imaging	II2	Apr03	27	ACR, SNM		1.07	1.07		Yes	
79100	XXX	R	Feb03	7	Radiolabled Monoclonal Antibody Infusion	JJ1	Apr03	28	ACR, SNM		1.32	1.32	Yes	Yes	
79400	XXX	R	Feb03	7	Radiolabled Monoclonal Antibody Infusion	JJ2	Apr03	28	ACR, SNM		1.96	1.96	Yes	Yes	
79403	XXX	N	Feb03	7	Radiolabled Monoclonal Antibody Infusion	JJ3	Apr03	28	ACR, SNM		2.25	2.25		Yes	
83716	XXX	R	Feb03	12	Lipoprotein Cholesterol Subclass				CLFS					No	
84155	XXX	R	Aug02	R	Urne Protein Test				CLFS					No	
84156	XXX	N	Aug02	R	Urne Protein Test				CLFS					No	
84157	XXX	N	Aug02	R	Urne Protein Test				CLFS					No	
84160	XXX	R	Aug02	R	Urne Protein Test				CLFS					No	
84165	XXX	R	Aug02	R	Urne Protein Test				CLFS					No	
85055	XXX	N	Nov02	W	Reticulated Platelet Assay				CLFS					No	

*delete*

*Error in Tracking*

CPT Code	Global Coding Period	CPT Change	CPT Date	CPT Issue Tab	Tracking Number	RUC Date	RUC S.S. Tab	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
85396	XXX	N	Nov02	Z	Comprehensive Coagulation Assessment	Q1	Feb03	18 CAP	0.47	0.37		Yes	
87040	XXX	R	Feb03	14	Bacterial Cultures		CLFS					No	
87045	XXX	R	Feb03	14	Bacterial Cultures		CLFS					No	
87046	XXX	R	Feb03	14	Bacterial Cultures		CLFS					No	
87070	XXX	R	Feb03	14	Bacterial Cultures		CLFS					No	
87075	XXX	R	Feb03	14	Bacterial Cultures		CLFS					No	
87269	XXX	N	Feb03	15	Cryptosporidium-Giardia Detection		CLFS					No	
87272	XXX	R	Feb03	15	Cryptosporidium-Giardia Detection		CLFS					No	
87328	XXX	R	Feb03	15	Cryptosporidium-Giardia Detection		CLFS					No	
87329	XXX	N	Feb03	15	Cryptosporidium-Giardia Detection		CLFS					No	
87660	XXX	N	Feb03	16	Trichomas Dectection by Nucleic Acid Detection		CLFS					No	
88112	XXX	N	Feb03	18	Cytopathology, Selective Cellular Enhancement Technique	KK1	Apr03	18 CAP	1.18	1.18		Yes	
88312	XXX	R	Feb03	19	Special Stains		CLFS					No	
88313	XXX	R	Feb03	19	Special Stains		CLFS					No	
88314	XXX	R	Feb03	19	Special Stains		CLFS					No	
88342	XXX	R	Feb02	EC-T	Tumor Morphometry		Apr03	30	0.85	0.85	Yes	Yes	
88358	XXX	R	Feb03	EC-T	Tumor Morphometry		Apr03	30 CAP	1.20	0.95		Yes	
88361	XXX	N	Feb03	EC-T	Tumor Morphometry		Apr03	30 CAP	1.35	0.94		Yes	
89055	XXX	R	Feb03	20	Fecal Leukocytes		CLFS					No	

CPT Code	Global Coding Period	Coding Change	CPT Date	CPT Issue Tab	Issue	Tracking Number	RUC Date	RUC S.S. Tab	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
89220	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures		CLFS						No	Renumbered Code from 89350
89225	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures		CLFS						No	Renumbered Code from 89355
89230	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures		CLFS						No	Renumbered Code from 89360
89235	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures		CLFS						No	Renumbered Code from 89365
89240	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures		CLFS						No	Renumbered Code from 89399
89250	XXX	R	Feb03	20	Reproductive Medicine Laboratory Procedures		CLFS						No	
89251	XXX	R	Feb03	20	Reproductive Medicine Laboratory Procedures		CLFS						No	
89252	XXX	D	Feb03	20	Reproductive Medicine Laboratory Procedures		CLFS						No	
89256	XXX	D	Feb03	20	Reproductive Medicine Laboratory Procedures		CLFS						No	
89258	XXX	R	Feb03	20	Reproductive Medicine Laboratory Procedures		CLFS						No	
89268	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures		CLFS						No	
89272	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures		CLFS						No	
89280	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures		CLFS						No	Renumbered Code from 89252

CPT Code	Global Coding Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
89281	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures			CLFS						No	Renumbered Code from 89252
89290	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures			CLFS						No	
89291	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures			CLFS						No	
89335	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures			CLFS						No	
89342	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures			CLFS						No	
89343	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures			CLFS						No	
89344	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures			CLFS						No	
89346	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures			CLFS						No	
89350	XXX	D	Feb03	20	Reproductive Medicine Laboratory Procedures			CLFS						No	
89352	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures			CLFS						No	Renumbered Code from 89256
89353	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures			CLFS						No	
89354	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures			CLFS						No	
89355	XXX	D	Feb03	20	Reproductive Medicine Laboratory Procedures			CLFS						No	
89356	XXX	N	Feb03	20	Reproductive Medicine Laboratory Procedures			CLFS						No	
89360	XXX	D	Feb03	20	Reproductive Medicine Laboratory Procedures			CLFS						No	

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC S.S. Tab	Specialty Rec	RUC Rec	Same as last year?	RVU	MFS	Comments
89365	XXX	D	Feb03	20	Reproductive Medicine Laboratory Procedures			CLFS					No	
89399	XXX	D	Feb03	20	Reproductive Medicine Laboratory Procedures			CLFS					No	
90655	XXX	N	Feb03	28	Influenza Vaccine			Vaccine					No	
90657	XXX	R	Feb03	28	Influenza Vaccine			Vaccine					No	
90658	XXX	R	Feb03	28	Influenza Vaccine			Vaccine					No	
90659	XXX	D	Feb03	2	Influenza Vaccine			Vaccine					No	
90693	XXX	N	May03	EC25	Vaccines			Vaccine					No	
90698	XXX	N	Nov02	3	Tetanus, Diphtheria Toxoid, and Acellular Pertussis Vaccine			Vaccine					No	
90703	XXX	N	May03	EC25	Vaccines			Vaccine					No	
90704	XXX	N	May03	EC25	Vaccines			Vaccine					No	
90705	XXX	N	May03	EC25	Vaccines			Vaccine					No	
90706	XXX	N	May03	EC25	Vaccines			Vaccine					No	
90707	XXX	N	May03	EC25	Vaccines			Vaccine					No	
90708	XXX	N	May03	EC25	Vaccines			Vaccine					No	
90718	XXX	N	May03	EC25	Vaccines			Vaccine					No	
90727	XXX	N	May03	EC25	Vaccines			Vaccine					No	
90733	XXX	N	May03	EC35	Vaccines			Vaccine					No	
90734	XXX	N	Aug02	S	Meningococcal Vaccine			Vaccine					No	

CPT Code	Global Coding Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
91110	XXX	N	Feb03	23	Capsule Tract Imaging	MM1	Apr03	31	ASGE, AGA		5.00	3.65			Yes
95990	XXX	R	Nov02	EC24	Refilling of Implantable Pumps	R1	Feb03	19	ASA, AAPM		0.00	0.00	Yes		Yes
95991	XXX	N	Nov02	EC24	Refilling of Implantable Pumps	R2	Feb03	19	ASA, AAPM		0.77	0.77			Yes
99024	XXX	R	Feb03	EC-O	Special Services, Procedures, and Reports				Editorial						Yes
99025	XXX	D	Feb03	EC-O	Special Services, Procedures, and Reports				Deleted						Yes
99050	XXX	R	Aug02	HIW	Special Services After Hours				Editorial						Yes
99293	XXX	R	May03	E	Pediatric Critical Care/Neonatal Critical Care				Editorial		16.00	16.00	Yes		Yes
99294	XXX	R	May03	E	Pediatric Critical Care/Neonatal Critical Care				Editorial		8.00	8.00	Yes		Yes
99295	XXX	R	May03	E	Pediatric Critical Care/Neonatal Critical Care				Editorial		16.00	16.00	Yes		Yes
99296	XXX	R	May03	E	Pediatric Critical Care/Neonatal Critical Care				Editorial		8.00	8.00	Yes		Yes
99512	XXX	R	Aug02	HIW	Home Visit Services				HHA						No
99551	XXX	D	Aug02	HIW	Home Infusion Codes				HHA						No
99552	XXX	D	Aug02	HIW	Home Infusion Codes				HHA						No
99553	XXX	D	Aug02	HIW	Home Infusion Codes				HHA						No
99554	XXX	D	Aug02	HIW	Home Infusion Codes				HHA						No
99555	XXX	D	Aug02	HIW	Home Infusion Codes				HHA						No
99556	XXX	D	Aug02	HIW	Home Infusion Codes				HHA						No

CPT Code	Global Coding Period	CPT Change	CPT Date	CPT Issue Tab	Tracking Number	RUC Date	RUC S.S. Tab	Specialty Rec	RUC Same Rec as last year?	RVU	MFS	Comments
99557	XXX	D	Aug02	HIW	Home Infusion Codes		HHA				No	
99558	XXX	D	Aug02	HIW	Home Infusion Codes		HHA				No	
99559	XXX	D	Aug02	HIW	Home Infusion Codes		HHA				No	
99560	XXX	D	Aug02	HIW	Home Infusion Codes		HHA				No	
99561	XXX	D	Aug02	HIW	Home Infusion Codes		HHA				No	
99562	XXX	D	Aug02	HIW	Home Infusion Codes		HHA				No	
99563	XXX	D	Aug02	HIW	Home Infusion Codes		HHA				No	
99564	XXX	D	Aug02	HIW	Home Infusion Codes		HHA				No	
99565	XXX	D	Aug02	HIW	Home Infusion Codes		HHA				No	
99566	XXX	D	Aug02	HIW	Home Infusion Codes		HHA				No	
99567	XXX	D	Aug02	HIW	Home Infusion Codes		HHA				No	
99568	XXX	D	Aug02	HIW	Home Infusion Codes		HHA				No	
99569	XXX	D	Aug02	HIW	Home Infusion Codes		HHA				No	
99601	XXX	N	Aug02	HIW	Home Infusion Codes		HHA				No	
99602	ZZZ	N	Aug02	HIW	Home Infusion Codes		HHA				No	

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2003

**Anesthesia Services: Mediastinoscopy and Diagnostic Thoracoscopy**

CPT revised existing code 00528 and created a new CPT code 00529 to differentiate between utilizing one lung ventilation and not utilizing one lung ventilation for anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy. When single lung ventilation is used for diagnostic thoracoscopy and surgical thoracoscopy the anesthesia procedure is more complex, therefore, a new code was created to describe the procedure using one lung ventilation. Technical advances have allowed for an increasing use of one-lung ventilation, therefore a new code was needed.

00528

Because the anesthesia codes are valued using a different system utilizing base units and time, the RUC concluded that the best way to determine the proper base units for these codes is to compare the recommended values to other anesthesia codes to determine if the relativity. The RUC could not value the code in any other manner such as a comparison to non-anesthesia codes since the base units contain physician work, practice expense and PLI and are used with time units as well. For CPT code 00528 *mediastinoscopy and diagnostic thoracoscopy not utilizing one lung ventilation*, the specialty recommended that the base unit remain at a value of 8 base units. In comparison to the reference code 00540 *Anesthesia for thoracoscopy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified* (base unit 12), the RUC felt that the recommended value of base units was appropriate given the differences in work between the two codes and also in comparison to the recommended value of 11 base units for the new code 00529 *mediastinoscopy and diagnostic thoracoscopy utilizing one lung ventilation*. The RUC also reviewed other anesthesia codes with base units of 8 to ensure that the recommended value for CPT code 00528 is appropriate. In addition, ASA stated that the vast majority of the coding for 00528 are for mediastinoscopy and not the more difficult diagnostic thoracoscopy. Therefore the base units should not change due to the coding revisions that specify the diagnostic thoracoscopy not utilizing one lung ventilation.

**The RUC recommends a base unit of 8 for code 00528.**

00529

The recommended base units for the new code 00529 *Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy utilizing one lung ventilation* was reviewed primarily in comparison to code 00528. The RUC also compared the recommended value to the reference service CPT code 00541 *Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing one lung ventilation* (base unit 15). Also the code was compared to CPT code 00210 *Anesthesia for intracranial procedures; not otherwise specified* (base unit 11). The RUC concluded that the recommended value was appropriate as it reflected the additional work of utilizing one lung ventilation in comparison to CPT code 00528.

**The RUC recommends a base unit of 11 for code 00529.**

CPT Code (•New)	Track ing Num- ber	CPT Descriptor	Global Period	Base Unit Recommendation
00520		<i>Anesthesia for closed chest procedures; (including bronchoscopy) not otherwise specified</i>		
00522		<i>needle biopsy of pleura</i>		
00524		<i>pneumocentesis</i>		
▲00528	G1	mediastinoscopy and diagnostic thoracoscopy <u>not utilizing one lung ventilation</u>	XXX	8
●00529	G2	mediastinoscopy and diagnostic thoracoscopy utilizing one lung ventilation	XXX	11

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

CPT Code: ▲ 00528 Tracking Number: G1 Global Period: XXX Recommended Base Unit Value: 8

**CPT Descriptor: Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy not utilizing one lung ventilation**

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** A 60-year old male with a 30-year history of smoking, coronary artery disease and mild COPD presents with large perihilar masses on chest radiograph and CT. No distinct masses are present in the lungs. Lung washings are non-diagnostic. The patient has well-controlled hypertension and no recent angina. Current medications include an antihypertensive agent and a bronchodilator. ECG shows evidence of an old infarction but no acute changes. Hemoglobin is slightly elevated and electrolytes are within normal limits. He is scheduled for a diagnostic mediastinoscopy with biopsy under general anesthesia.

**Description of Pre-Service Work:**

- Pre-operative visit and evaluation of cardiovascular, neurological and pulmonary systems
- Review surgeon's history and physical and any notes from consultants
- Review of pulmonary function tests, ECG, laboratory tests, medications, allergies and past medical and surgical history
- Explain anesthetic options and risks to patient, answer questions and obtain consent
- Prepare anesthetic drugs
- Check anesthesia machine is operating per manufacturer's guidelines

**Description of Intra-Service Work:**

- Obtain intravenous access
- Transport patient to OR, apply routine monitors and confirm placement after patient is positioned on OR table
- Preoxygenation by mask
- Induction of anesthesia with intravenous lidocaine, fentanyl, propofol and a neuromuscular blocking agent
- Insertion of endotracheal tube -- confirm position and secure with tape
- Protection of eyes, extremities, and pressure points
- Delivery of inhalational and intravenous anesthetics
  - constant attention to vital signs
  - constant monitoring of oxygenation and respiratory status and degree of neuromuscular block
  - intervention to maintain normothermia, regulation of depth of anesthesia and control of BP and cardiac output. IV fluids given to maintain hydration and treat hypotension
- Prepare for emergence
  - inhalation agents withdrawn and residual neuromuscular blockage reversed using anticholinesterase and anticholinergic drugs
  - extubate trachea after determining adequacy of spontaneous ventilation
- Patient moved to stretch and transferred with supplemental oxygen by facemask to PACU

**Description of Post-Service Work:**

- Vital signs checked and level of consciousness is determined
- Assessment of airway maintenance; patient's ability to handle secretions and adequacy of ventilation
- Additional analgesics ordered as needed
- History of procedure and patient's history provided to PACU nurse
- Determine when patient is fit to be turned over to PACU care

**SURVEY DATA**

<b>Presenter(s):</b>	Karl E. Becker, M.D., James D. Grant, M.D.				
<b>Specialty(s):</b>	American Society of Anesthesiologists				
<b>CPT Code:</b>	▲00528 Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy not utilizing one lung ventilation				
<b>Sample Size:</b> 130	<b>Resp no:</b> 41	<b>Resp %:</b> 31%			
<b>Sample Type:</b> Panel					
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey Base Unit Value:</b>	5	8	10	12	18
<b>Pre-Service Evaluation Time:</b>			30		
<b>Pre-Service Positioning Time:</b>					
<b>Pre-Service Scrub, Dress, Wait Time:</b>					
<b>Intra-Service Time:</b>	20	60	80	90	130
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15	Included			
<b>Critical Care time/visit(s):</b>					
<b>Other Hospital time/visit(s):</b>		Included			
<b>Discharge Day Mgmt:</b>					
<b>Office time/visit(s):</b>					

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Base Unit Value</u>
00540	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified	XXX	12

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

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

**TIME ESTIMATES (Median)**

<b>New/Revis. CPT Code:</b>	<b>Key Reference CPT Code:</b>
<b>▲ 00528</b>	<b>00540</b>

Median Pre-Service Time	30	30
Median Intra-Service Time	80	120
Median Immediate Post-service Time	15	30
Median Critical Care Time		
Median Other Hospital Visit Time		
Median Discharge Day Management Time		
Median Office Visit Time		
<b>Median Total Time</b>	<b>125</b>	<b>180</b>

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.59	3.74
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.66	3.83
Urgency of medical decision making	3.63	3.83

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.34	3.70
Physical effort required	3.24	3.52

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.95	4.00
---	------	------

Outcome depends on the skill and judgement of physician	3.76	3.83
---	------	------

Estimated risk of malpractice suit with poor outcome	3.56	3.61
--	------	------

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.46	3.52
----------------------------------	------	------

Intra-Service intensity/complexity	3.61	3.83
------------------------------------	------	------

Post-Service intensity/complexity	3.12	3.43
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

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

The ASA reached its final conclusion after evaluation of this procedure by the ASA RVS committee and consideration of the similarities and dis-similarities of this procedure with the key reference service.

We are recommending 8 base units for this code. This code had not been subject of a RUC survey prior to this revision. The recommended value is equal to the 25<sup>th</sup> percentile and lower than the survey mean of 9.88. Most of the respondents agreed that the vignette described their typical patient however several noted that their typical patient would be sicker with more co-morbid conditions.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

**FREQUENCY INFORMATION**

How was this service previously reported? 00528 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Anesthesiology  Commonly  Sometimes  Rarely

Specialty \_\_\_\_\_ Commonly  Sometimes  Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 25,000

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty Anesthesiology Frequency 12,500

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

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

---

CPT Code: •00529 Tracking Number: G2 Global Period: XXX Recommended Base Unit Value: 11

**CPT Descriptor: Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy utilizing one lung ventilation**

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** A 65-year old man presents with six-month history of lower lateral chest wall pain and shortness of breath. Chest X-ray shows pleural thickening of the entire lateral chest wall. He is taken to the operating room for diagnostic thoracoscopy under general anesthesia, which reveals mesothelioma.

**Description of Pre-Service Work:**

- Pre-operative visit and evaluation of cardiovascular, neurological, and pulmonary systems
- Review of surgeon's history and physical and any notes from consultants
- Review of pulmonary function tests, ECG, laboratory tests, medications, allergies and past medical and surgical history
- Explain anesthetic options and risks to patient, answer questions and obtain consent
- Prepare anesthetic drugs
- Check anesthesia machine is operating per manufacturer's guidelines
- Prepare equipment and supplies for endobronchial intubation including fiberoptic bronchoscope

**Description of Intra-Service Work:**

- Obtain intravenous access
- Administer pre-medication (sedation, anti-aspiration, anti-asthmatic drugs, etc)
- Transport patient to OR, apply routine monitors and confirm placement after patient is positioned on or table
- Preoxygenation by mask
- Induction of anesthesia with intravenous lidocaine, fentanyl, propofol and a neuromuscular blocking agent
- Insertion of endobronchial tube -- confirm position with fiberoptic bronchoscope and auscultation and secure with tape
- Protection of eyes, extremities and pressure points
- Position in lateral decubitus position
- Reconfirm endobronchial tube placement with fiberoptic bronchoscopy and auscultation. Adjust ventilation parameters as required by change in patient position
- Delivery of inhalational and intravenous anesthetics
  - constant attention to vital signs
  - constant monitoring of oxygenation and respiratory status and degree of neuromuscular block
  - initiate single lung ventilation, adjust ventilator settings, assure normoxia and normocarbida. Application of CPAP and/or PEEP as needed
  - intervention to maintain normothermia, regulation of depth of anesthesia and control of BP and cardiac output. IV fluids given to maintain hydration and treat hypotension
- Prepare for emergence
  - resume two-lung ventilation, manage atelectasis
  - inhalation agents withdrawn and residual neuromuscular blockage reversed using anticholinesterase and anticholinergic drugs
  - extubate trachea after determining adequacy of spontaneous ventilation
- Patient moved to stretcher and transferred with supplemental oxygen by facemask to PACU

**Description of Post-Service Work:**

- Vital signs checked and level of consciousness is determined
- Assessment of airway maintenance; patient's ability to handle secretions and adequacy of ventilation
- Additional analgesics ordered as needed
- History of procedure and patient's history provided to PACU nurse
- Determine when patient is fit to be turned over to PACU care

**SURVEY DATA**

<b>Presenter(s):</b>	Karl E. Becker, M.D., James D. Grant, M.D.				
<b>Specialty(s):</b>	American Society of Anesthesiologists				
<b>CPT Code:</b>	•00529 Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy utilizing one lung ventilation				
<b>Sample Size:</b> 130	<b>Resp no:</b> 41	<b>Resp %:</b> 31%			
<b>Sample Type:</b> Panel					
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey Base Unit Value:</b>	6	12	14	15	20
<b>Pre-Service Evaluation Time:</b>			30		
<b>Pre-Service Positioning Time:</b>					
<b>Pre-Service Scrub, Dress, Wait Time:</b>					
<b>Intra-Service Time:</b>	25	80	90	120	240
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	20	Included			
<b>Critical Care time/visit(s):</b>					
<b>Other Hospital time/visit(s):</b>		Included			
<b>Discharge Day Mgmt:</b>					
<b>Office time/visit(s):</b>					

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Base Unit Value</u>
00541	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing one lung ventilation	XXX	15

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

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

**TIME ESTIMATES (Median)**

	<u>New/Revis. CPT Code: • 00529</u>	<u>Key Reference CPT Code: 00541</u>
Median Pre-Service Time	30	* 30
Median Intra-Service Time	90	* 150
Median Immediate Post-service Time	20	* 22.5
Median Critical Care Time		
Median Other Hospital Visit Time		
Median Discharge Day Management Time		
Median Office Visit Time		
Median Total Time	140	202.5

\* Code 00541 is not included in version 4.02 of the RUC database. Times for this reference service have been taken from the work summary presented to the RUC in April 2002 for code 00541.

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.93	4.19
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.05	4.19
Urgency of medical decision making	4.02	4.34

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.46	4.59
Physical effort required	4.05	4.22

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.29	4.56
Outcome depends on the skill and judgement of physician	4.32	4.53
Estimated risk of malpractice suit with poor outcome	3.85	3.97

**INTENSITY/COMPLEXITY MEASURES**CPT Code  
• 00529Reference  
Service  
00541**Time Segments (Mean)**

Pre-Service intensity/complexity	3.83	4.13
Intra-Service intensity/complexity	4.17	4.53
Post-Service intensity/complexity	3.59	3.81

**ADDITIONAL RATIONALE**

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

The ASA reached its final conclusion after evaluation of this procedure by the ASA RVS committee and consideration of the similarities and dis-similarities of this procedure with the key reference service.

After review of the survey results and comparing the relationship of 00528 and 00529 with that of 00540 and 00541, ASA is recommending 11 base units for code 00529. While this value is slightly less than the 25<sup>th</sup> percentile, it preserves an appropriate rank order of the base units assigned to these codes. Some of the respondents felt that the typical patient would have co-morbidities such as COPD and CAD.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

**FREQUENCY INFORMATION**

How was this service previously reported? 00528 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Anesthesiology  Commonly  Sometimes  Rarely

Specialty \_\_\_\_\_  Commonly  Sometimes  Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 7,000

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty Anesthesiology Frequency 3,500

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Anesthesia for Pelvic Acetabular Fracture**

**01173**

The CPT Editorial Panel approved a new code to describe the provision of anesthesia for patients who have sustained an injury that disrupts the pelvic circle. These patients are typically multiple trauma victims with multiple and significant injuries and acute co-morbidities that directly influence their anesthetic care and a new code is needed to accurately describe the anesthesia work. The RUC suggested changes to the CPT descriptor to reflect that the anesthesia is for acetabular fractures and the CPT Editorial panel subsequently agreed to the following descriptor for code 01173: *Anesthesia for open repair of fracture disruption of pelvis or column fracture involving acetabulum*. The RUC felt that such a descriptor more closely matched the vignette used to value the code since the base unit value should reflect the anesthesia work involved with a trauma victim that requires complex anesthetic management.

The RUC focused on placing the new code 01173 in proper rank order with other ASA codes since the Anesthesia codes are valued on a different scale than all other codes in the RBRVS. The new code intensity measures were examined in comparison to the reference code 01215 *Anesthesia for open procedures involving hip joint; revision of total hip arthroplasty*, (base unit =10) and determined that the higher intensity values for the new code supported a higher base unit. In addition, the new code was also compared to other anesthesia codes with base units of 15, such as code 00500 *Anesthesia for procedures on esophagus*. Other codes with base units of 10 were also examined, such as 01212 *Anesthesia for open procedures involving hip joint; hip disarticulation*. The RUC concluded that the best way it could value the new code was to compare it to the existing base units of other anesthesia codes and determining the proper rank order. The RUC concluded that a base unit of 12 placed this code in proper rank order with other anesthesia codes.

**The RUC recommends 12 base units for code 01173.**

CPT Code (●New)	Track ing Num- ber	CPT Descriptor	Global Period	Base Unit Recommenda- tion
●01173	S1	Anesthesia for open repair of fracture disruption of pelvis or column fracture involving acetabulum	XXX	12

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

---

CPT Code: 01173      Tracking Number: S1    Global Period: XXX    **Recommended Base Unit Value: 12**

CPT Descriptor:      ~~Anesthesia for open repair of fracture disruption of pelvis~~—Anesthesia for open repair of fracture disruption of pelvis or column fracture involving acetabulum

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** A 29-year-old male involved in a motor vehicle accident 36 hours previously presents to the operating room for open repair of an acetabular wall dislocation fracture. Such patients are typically multiply injured; thoracic and abdominal injuries add to the complexity of the anesthetic management. Associated injuries include a recently repaired ipsilateral tib/fib fracture, recently sutured facial lacerations, a pulmonary contusion and a ruptured spleen. He has already received four units of packed red blood cells, 20 units of platelets and 2 units of fresh frozen plasma for stabilization of continually dropping hemoglobin and correction of coagulopathy. He is currently in a neck collar as cervical spine stability is still uncertain. He is receiving oxygen by facemask, is oriented to person, and is receiving intravenous morphine sulfate for analgesia.

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

Comments received from respondents who found the vignette atypical:

- These patients present in extremis with blood in abdomen and possible associated urologic or vascular injuries. They arrive in the OR in an extremely unstable state.
- Usually due to MVA -- multiple system trauma

**Description of Pre-Service Work:** The patient is transferred to the pre-op holding area from the intensive care unit where the RN gives a report to the Anesthesiologist. The patient's recent clinical course and vital signs are reviewed. The Anesthesiologist reviews the medical record and the anesthetic record and progress notes from the previous evening. Neither neurosurgery or orthopedic surgery is able to adequately determine cervical spine stability. In addition, the recent notes by the trauma surgeon as well as the consulting orthopedic, plastic and general surgeons are reviewed. Current laboratory data and imaging studies are noted. A directed physical exam is performed with special attention to pulmonary, cardiac and mental status. Plans, risks, and expectations are reviewed with the patient and his family and all questions are answered as consent is obtained for the planned anesthetic care.

**Description of Intra-Service Work:** Venous access sites are examined and a new 14 gauge peripheral intravenous line is placed. A radial artery is cannulated (separately reported). In addition, a central venous pressure monitor (separately reported) is placed into the jugular or subclavian veins to assess volume status during the periods of rapid blood loss. At this time, topicalization for the patient's airway has begun, both by local anesthetic spray and a translaryngeal injection. The patient is transferred to the operating room with oxygen being continued by face mask. Additional intravenous analgesics are administered prior to carefully moving the patient to the operating table. ECG, non-invasive blood pressure, and pulse oximetry monitoring are established. Prior to inducing general anesthesia, further topical anesthesia and intravenous sedation are provided and gas analysis including end tidal CO<sub>2</sub> monitoring is initiated. An endotracheal tube is placed and after confirming correct positioning with auscultation and end tidal CO<sub>2</sub> analysis, the endotracheal tube is secured and mechanical ventilation commenced. Mild hypotension post induction is corrected pharmacologically with agents that had been prepared in advance. Inhalational anesthetics are added to maintain anesthesia. A high flow fluid warmer with IV fluids is attached to the recently placed 14 gauge IV. A forced-air warming blanket is placed and an esophageal stethoscope/temperature probe is inserted orally in order to attempt to maintain normothermia. Careful attention is given to positioning and padding, as the potential for a prolonged surgery exists. Inhalational anesthetics and intravenous narcotics are carefully titrated to maintain anesthesia and hemodynamic stability. Neuromuscular blockade is regularly monitored using

peripheral nerve stimulation and additional paralytic agents administered to maintain adequate surgical relaxation. Intravenous fluids are administered at a rapid rate to replace substantial insensible losses and

surgical blood loss. Urinary output and temperature are monitored. Throughout the duration of the procedure, assessment and treatment of surgical blood loss and maintenance of stable hemodynamics are undertaken. This assessment and treatment is generally quite complex as there is often massive bleeding. Retroperitoneal hematoma is often present. Shock is always a concern. Intermittent analysis of arterial blood gases and continual evaluation of the central venous pressure are evaluated and any abnormalities are addressed. As the surgical procedure nears completion, adequacy of neuromuscular function is determined, inhalational anesthetics are gradually reduced and the patient is attempted to be weaned from mechanical ventilation. Depending of the various intraoperative conditions, the patient may begin to breathe spontaneously and morphine is titrated intravenously to provide for analgesia yet allow for planned extubation at the conclusion of the procedure. The patient's level of consciousness, ventilatory efforts, capnogram and oximetry are assessed to determine the adequacy of spontaneous respiration. If these parameters appear satisfactory, the patient is extubated and mask oxygen administered. Otherwise the patient will remain on full ventilatory support and taken directly to the ICU. The patient is then transported to the PACU with continuous oxygen by mask or transported directly to the Intensive Care Unit on full ventilatory support.

**Description of Post-Service Work:** In either the ICU or PACU, a patient history and synopsis of intraoperative events, including fluids administered, blood loss, urinary output, drugs administered, and vital sign trends is provided to the nursing staff. The anesthesiologist continues to participate in the management of postoperative analgesia, fluid balance and respiratory care while the patient is cared for in the PACU. When the patient is stable, the anesthesiologist discharges the patient from the post anesthesia care unit. The patient is seen again the next day to evaluate the patient's recovery from anesthesia and determine if any anesthesia related complications occurred.

## SURVEY DATA

<b>Presenter(s):</b>	James D. Grant, M.D.				
<b>Specialty(s):</b>	American Society of Anesthesiologists				
<b>CPT Code:</b>	01173				
<b>Sample Size:</b>	198	<b>Resp n:</b>	31	<b>Resp %:</b>	15%
<b>Sample Type:</b> Panel					
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		8	11	12	15
<b>Pre-Service Evaluation Time:</b>		15	26	35	59
<b>Pre-Service Positioning Time:</b>					
<b>Pre-Service Scrub, Dress, Wait Time:</b>					
<b>Intra-Service Time:</b>		40	210	300	360
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	30	Included			
<b>Critical Care time/visit(s):</b>					
<b>Other Hospital time/visit(s):</b>		Included			
<b>Discharge Day Mgmt:</b>					
<b>Office time/visit(s):</b>					

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Base Unit Value</u>
01215	Anesthesia for open procedures involving hip joint; revision of total hip arthroplasty	10

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

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

**Number of respondents who choose Key Reference Code: 15**

**TIME ESTIMATES (Median)**

	<u>New/Revis. CPT Code: 0117X</u>	<u>Key Reference CPT Code: 01215</u>
Median Pre-Service Time	35	15
Median Intra-Service Time	300	120
Median Immediate Post-service Time	30	15
Median Critical Care Time		
Median Other Hospital Visit Time		
Median Discharge Day Management Time		
Median Office Visit Time		
<b>Median Total Time</b>	<b>365</b>	<b>150</b>

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.29	2.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	3.00
Urgency of medical decision making	3.93	2.80

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.13	3.20
Physical effort required	3.93	3.20

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.33	3.40
---	------	------

Outcome depends on the skill and judgement of physician	4.27	3.40
---	------	------

Estimated risk of malpractice suit with poor outcome	4.07	3.53
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****0117X****Reference****Service<sub>t</sub>****01215****Time Segments (Mean)**

Pre-Service intensity/complexity	4.20	3.13
----------------------------------	------	------

Intra-Service intensity/complexity	4.13	3.33
------------------------------------	------	------

Post-Service intensity/complexity	3.80	2.93
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

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

The complexity/intensity measurements for the new code were higher than those for the reference service selected. None of the other reference services were selected by more than 4 respondents so we have confidence in the comparisons. The vast majority of the respondents agreed that the vignette represented their typical patient; the few who did not indicated that their typical patient would have significant co morbidities. The survey median of 12 base units is an appropriate value for this service.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

**FREQUENCY INFORMATION**

How was this service previously reported? 01210, 01170, 01120 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Anesthesiology \_\_\_\_\_ Commonly  Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology \_\_\_\_\_ Frequency 2,500 - 4,000

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty Anesthesiology \_\_\_\_\_ Frequency 800

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2003

**Anesthesia for External Cephalic Version Procedure**

CPT created new code 01958 *Anesthesia for external cephalic version procedure* due to an increase over the past few years in the demand for anesthesia services for pregnant women with babies presenting in a breech position. Recent studies have shown that the success rate is enhanced by the woman having adequate analgesia. Typically, unsuccessful external cephalic versions go on to a planned cesarean delivery. If the external cephalic version procedure is successful, a vaginal delivery occurs at a later date.

The RUC compared the new code primarily to the reference code 01960 *Anesthesia for vaginal delivery only* (base unit = 5) and concluded that the anesthesia work was similar with these two codes. The RUC also examined other anesthesia codes to determine proper rank order codes such as 00635 *Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture* (base unit = 4), which involves less work than code 01958. Primarily the intensity and risk of the new code 01958 is greater due to increase risk of fetal compromise as a result of the moving of the baby. Also code 01916 *Anesthesia for diagnostic arteriography/venography* (base unit = 5) was compared and determined to have similar physician work.

**The RUC recommends a base unit of 5 for code 01958**

CPT Code (•New)	Track ing Num- ber	CPT Descriptor	Global Period	Base Unit Recommendation
•01958	H1	Anesthesia for external cephalic version procedure	XXX	5

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

---

CPT Code: • 01958 Tracking Number: H1 Global Period: XXX Recommended Base Unit Value: 5

**CPT Descriptor: Anesthesia for external cephalic version procedure**

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** A 31-year old woman, Gravida 2 Para 1, is 38 weeks and 5 days pregnant. Her first pregnancy was uncomplicated and she delivered vaginally on her estimated due date. She received a neuraxial analgesic (a continuous epidural, CPT code 01967) for relief of pain during labor and delivery. With this pregnancy, her clinical examination at 32 weeks suggested a breech presentation, which was confirmed by transabdominal ultrasound examination. Subsequent sonographic examinations continued to show a frank breech presentation. After considering the options, the patient and her obstetrician, both desiring a vaginal delivery, elected to attempt an external cephalic version (ECV). For the attempt at ECV, the patient and obstetrician requested pain relief. A neuraxial analgesic consisting of epidural catheter and local anesthesia combined with narcotic supplementation was recommended.

**Description of Pre-Service Work:** The next day, the patient was admitted to the labor and delivery floor at 0630 hrs, having had no oral intake for nine hours. The anesthesiologist reviewed the admission history and physical and the pre-anesthesia questionnaire. An anesthetic history and physical was obtained, focusing on allergies, medications, previous anesthetic experiences, family history of anesthetic complications as well as a systems review emphasizing the airway, cardiac, respiratory, neurological, hepatic and renal systems. The anesthesiologist examined the airway, performed cardiac and pulmonary auscultation and examined the spine. An 18 gauge intravenous catheter was inserted in a dorsal hand vein, blood was sent to the laboratory for a complete blood count and a "type and screen" was sent to the hospital blood bank. Prior to initiating the attempt at ECV, the obstetrician and anesthesiologist reviewed the analgesic/anesthetic and delivery options with the patient and her husband, and informed consent was obtained. The delivery options discussed included: 1) if the ECV is successful and the fetus showed no untoward effects, she would be sent home to await the onset of spontaneous labor; 2) if unsuccessful, and the fetus remained stable, an elective cesarean delivery would be performed later that day; and 3) if unsuccessful and the fetus showed signs of distress, a cesarean delivery would be performed immediately. In the event of a cesarean section, the options of utilizing the indwelling epidural with more potent anesthetic agents or proceeding to general anesthesia were discussed. The risks of the planned anesthetic were discussed with the patient and her questions were answered.

**Description of Intra-Service Work:** In order to minimize the likelihood of labor resulting from the version manipulations, a tocolytic, terbutaline, was administered on the order of the obstetrician and the patient was given 30cc of sodium citrate orally. With the mother being monitored with electrocardiogram, pulse oximetry and non-invasive blood pressure cuff and external fetal monitors in place, the patient was placed in the sitting position. After sterile preparation of the lumbar spine region and under local anesthesia, an epidural needle was advanced into the lumbar epidural space and a catheter was advanced approximately 4 cm into the epidural space. The epidural needle was removed; 3 cc of 2% lidocaine with 1:200,000 epinephrine as a "test-dose" was injected via the catheter. After one minute there was no change in the mother's pulse or blood pressure and no evidence of a subarachnoid injection, so 12 ml of .25% bupivacaine and 100 mcg. of fentanyl were injected in divided doses. The patient was repositioned in the supine position and a roll placed under the patient's right hip to create left uterine displacement. Vital signs were carefully monitored with particular attention to blood pressure. With adequate analgesia, and under ultrasound guidance, the obstetrician began the ECV attempt. The external rotation was successful as demonstrated by physical assessment and by ultrasound examination.

**Description of Post-Service Work:** The epidural infusion was discontinued and the catheter was removed. On examination, the catheter was noted to be intact. The patient was monitored in the birthing room for vital signs and neurologic function. An external monitor for the fetus was continued. Two hours after the procedure, once the patient was able to ambulate without assistance and able to urinate, she was discharged home. The anesthesiologist evaluated the patient before discharge and recorded a note in the medical record.



**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Base Unit Value</u>
01960	Anesthesia for vaginal delivery only	XXX	5

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

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

**TIME ESTIMATES (Median)**

	<b>New/Revis. CPT Code: • 01958</b>	<b>Key Reference CPT Code: 01960</b>
Median Pre-Service Time	15	10
Median Intra-Service Time	40	45
Median Immediate Post-service Time	15	15
Median Critical Care Time		
Median Other Hospital Visit Time		
Median Discharge Day Management Time		
Median Office Visit Time		
<b>Median Total Time</b>	<b>70</b>	<b>70</b>

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.68	2.47
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.56	2.37
Urgency of medical decision making	4.07	2.95

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.27	3.21
Physical effort required	3.00	2.89

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.46	3.05
Outcome depends on the skill and judgement of physician	3.27	3.11
Estimated risk of malpractice suit with poor outcome	4.37	4.00

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code  
• 01958**      **Reference  
Service  
01960**

**Time Segments (Mean)**

Pre-Service intensity/complexity	2.66	2.47
Intra-Service intensity/complexity	3.24	3.00
Post-Service intensity/complexity	2.37	2.00

**ADDITIONAL RATIONALE**

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

The ASA reached its final conclusion after evaluation of this procedure by the ASA RVS committee and consideration of the similarities and dis-similarities of this procedure with the key reference service.

We reviewed the data and recommend a base unit value of 5 for this code. This is equal to both the 25<sup>th</sup> percentile and the survey median. The new code's Intensity/Complexity Measures consistently ranked higher than the reference service of 01960 (5 base units) but we feel that 5 base units is an accurate value for the service.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

**FREQUENCY INFORMATION**

How was this service previously reported? Most frequently with code 00800 Anesthesia for procedures on lower anterior abdominal wall; NOS. There may be instances in which code 01960 or 01961 was used. (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Anesthesiology  Commonly  Sometimes  Rarely

Specialty \_\_\_\_\_ Commonly  Sometimes  Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology Frequency 40,000

According to the National Center for Health Statistics, there were approximately 4 million births in the US in 2000. It is estimated that malpresentation is present in 4% of all pregnancies. ECV would be attempted in 25% of these cases.

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty Anesthesiology Frequency <30

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Hyoid Myotomy and Suspension**

The CPT Editorial Panel created one new code 21685, *Hyoid myotomy and suspension*, to describe a surgical procedure to help correct sleep-disordered breathing (obstructive sleep apnea syndrome) by functionally enlarging the retrolingual hypopharyngeal airway. There is no current code that adequately describes this procedure. The specialty society originally presented the code at the February 2003 RUC meeting. The RUC requested that the specialty society revise the code's vignette and re-survey the code.

Due to conflicts in scheduling the specialty society determined that it should hold off on its re-presentation of recommendations until September 2003. Given the relatively low volume of cases, the RUC and the specialty society agreed that CPT code 21685 should be carrier priced for 2004. A recommendation from the RUC will be submitted to CMS immediately following the September 2003 RUC meeting.

**The RUC recommends the carrier price for CPT code 21685.**

CPT Code (•New)	Track ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
•21685	11	Hyoid myotomy and suspension	090	Carrier Price

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2003

**Lateral Extracavitary Technique Vertebral Corpectomy and Arthrodesis**

The CPT Editorial Panel created six new codes: 22532, 22533, 22534, 63101, 63102 and 63103 to describe the lateral extracavitary approach when performing vertebral corpectomy and arthrodesis. The current codes do not capture the operative technique and work involved with performing these procedures with a lateral extracavitary approach.

22532

The RUC examined code 22532 *Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); thoracic*. It was determined by the RUC after reviewing the reference code 22556 *Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); thoracic*; (RVU 23.46) that the intra-service time of the new code (intra-service time=170 minutes) is similar to the intra- and post-service time of the reference code (intra-service time=180 minutes). However, the new code had a higher pre-service time. The RUC agreed that a significant amount of pre-time is necessary as the patient positioning is more extensive, and the pre-service evaluation time is longer as these are typically older patients with more medical co-morbidities. In addition, the intra-service period of the new code was deemed more intense than the reference code. Therefore, the RUC agreed with the specialty society that the 25<sup>th</sup> percentile RVW for 22532, as it reflects the appropriate comparison to 22556. **The RUC recommends a work relative value of 24.00 for 22532.**

22533

The RUC examined code 22533 *Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); lumbar*. It was determined by the RUC after reviewing the reference code 22558 *Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); lumbar*; (RVU=22.28) that the new code and the reference code both had 180 minutes of intra-service time and similar post-service time. However, the new code has higher pre-service time. The RUC agreed that a significant amount of pre-time is necessary as the patient positioning is more extensive, and the pre-service evaluation time is longer as these are typically older patients with more medical co-morbidities. In addition, the intra-service period of the new code was deemed more intense than the reference code. Therefore, the

RUC agreed with the specialty society that the 25<sup>th</sup> percentile RVW for 22533, as it reflects the appropriate comparison to 22558. **The RUC recommends a work relative value of 23.12 for 22533.**

#### 22534

The RUC examined code 22534 *Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional interspace (List separately in addition to code for primary procedure)*. It was determined by the RUC after reviewing the reference code 22585 *Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)* (RVU=5.53) that the intra-service time of the new code (60 minutes) was higher than the intra-service time of the reference code (45 minutes). In addition, the new code was deemed more intense and required additional technical skill and effort when compared to the reference code. Therefore, the RUC agreed with the specialty society that the increased time and intensity required to perform this procedure support the specialty society's median value of their survey (work RVU = 6.00), which was minimally higher than the relative work value associated with the reference code (RVU = 5.53). **The RUC recommends a work relative value of 6.00 for 22534.**

#### 63101 and 63102

The RUC examined codes 63101 *Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retracted bone fragments); thoracic, single segment* and 63102 *Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retracted bone fragments); lumbar, single segment*. The majority of the respondents who perform this procedure indicated that the key reference service code should be 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*; (RVU=35.57). It was determined by the RUC after reviewing the reference code that the intra-service time of the new code (215 minutes) was less than the intra-service time of the reference code (265 minutes). However, the new code was deemed more intense than the reference code. Therefore, the RUC agreed with the specialty society that the median survey RVW (32.00) is recommended for 63101 and 63102. This recommendation is less than the work value of the reference code and fairly balances the slightly higher intensity intra-service component with lower intra-service time. **The RUC recommends a work relative value of 32.00 for 63101 and 63102.**

63103

The RUC examined code 63103 *Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg. for tumor or retropulsed bone fragments); thoracic or lumbar, each additional level (List separately in addition to code for primary procedure)*. The majority of the respondents who perform this procedure indicated that the key reference service code should be CPT code 63088 *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; each additional segment (List separately in addition to code for primary procedure)*. (RVU=4.33). It was determined by the RUC that the intra-service time of the new code (60 minutes) was less than the intra-service time of the reference code (67 minutes). However, the new code was consistently identified as being more intense and requiring additional technical skill/effort when compared to the reference code. This rationale supports the higher work value reflected in the median survey result compared with the reference service. **The RUC recommends the survey median RVW of 5.00 for 63103.**

Practice Expense

The practice expense for 22532, 22533, 63101 and 63102 follows the PEAC accepted neurosurgery complex spine procedures packages. There are no practice expense inputs requested for 22534 and 63103, as these are add-on codes. The practice expense recommendations presented by the specialty society were accepted by the RUC.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
•22532	J1	Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); thoracic	090	24.00
•22533	J2	lumbar	090	23.12

CPT Code (•New)	Track ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
+•22534	J3	<p>thoracic or lumbar, each additional vertebral segment</p> <p>(List separately in addition to code for primary procedure)</p> <p>(Use 22534 in conjunction with codes 22532 and 22533)</p>	ZZZ	6.00
•63101	J4	<p>Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic single segment</p>	090	32.00
•63102	J5	<p>lumbar, single segment</p>	090	32.00
+•63103	J6	<p>thoracic or lumbar, each additional segment</p> <p>(List separately in addition to code for primary procedure)</p> <p>(Use 63103 in conjunction with codes 63101 and 63102)</p>	ZZZ	5.00

CPT Code: 22532

Tracking No: J1 Global: 090

Recommended RVW: 24.00

**Descriptor:** Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic

---

**SURVEY Vignette (Typical Patient)**

A 63-year-old man presents with progressive thoracic spine pain and normal lower extremity strength and sensation. Plain X-rays showed a T10-T11 degenerated disk space, anterior translation of the vertebral body, and collapse of the disk space height. An MRI scan showed a broad disk protrusion at T10-T11 without significant compression of the spinal cord and advanced degenerative changes of the end plates and ligaments. At operation, an arthrodesis is performed using a lateral extracavitary approach. Postoperative hospital care and office visits are conducted as necessary through the 90-day global.

---

**Clinical Description Of Service:**

**Pre service work:**

The medical record is reviewed to ensure that the patient is stable for the planned surgical procedure. The radiographic studies are reviewed showing the bone injury and the compression of the spinal cord. Radiographic findings are correlated with the clinical exam and the surgical plan is confirmed. The surgical decompression of the spinal cord with lateral extracavitary discectomy will require placement interbody bone graft for anterior arthrodesis and reconstruction of the spine. The surgeon confers with the patient and family; explaining the current condition and the need for surgical intervention. Questions are answered, consent obtained and a note written in the record. He confers with the Anesthesiologist and the Operating Room to review positioning, the intraoperative plan and equipment needs. After the patient is anesthetized, he is log-rolled and positioned on the operative table. The surgical site is prepped and draped into a sterile field.

**Intraservice work:**

A midline incision is made with an inferior curve out laterally to allow exposure of the paraspinous muscle bundle, centered over the fractured segment. The paraspinous muscles are elevated from the spinous processes and laminae with the electrocautery unit. The right side paraspinous muscle bundle is then divided laterally and elevated off the ribs allowing for retraction towards the midline. Intraoperative imaging is used to correctly identify the T10-11 interspace and the associated rib is dissected from the intercostal muscles and underlying pleura bluntly to avoid pneumothorax. The T11 rib is resected from the posterior bend to the costovertebral junction in a single piece. The intercostal nerve is identified and traced back to the neural foramen. The associated transverse process, lateral portion of the facet and pedicle are removed with the high-speed drill exposing the lateral aspect of the dural sac and the dorsolateral aspect of the vertebral body. The parietal pleura is gently depressed with a dampened sponge and retracted, exposing the lateral surface of the vertebral body. The nerve root may be divided or gently retracted superiorly to allow visualization of the posterior cortical margin of the vertebral body. A variety of curettes and pituitary rongeurs are used to remove the degenerated T10-11 disc material from the space. The cartilage is scraped from the vertebral endplates and the bone is then decorticated with the high-speed drill. Structural bone graft (graft harvest reported separately) is tamped into position between the endplates under direct vision for interbody arthrodesis. Extreme care is used to avoid compression of the spinal cord. If clinically indicated, spinal instrumentation is inserted (reported separately). A drain is placed in the deep space and a multilayer closure is undertaken.

**Post-service work:**

Dressings are applied. The patient is rolled onto a recovery bed and examination shows him to be moving his legs equivalent to preop. A chest radiograph is obtained to evaluate for a pneumothorax. Orders are written and a note is dictated. The surgeon maintains contact with ICU staff with respect to neuro checks. Orders are given for IV fluids and narcotic analgesics. During the hospitalization, the patient is examined for neurologic function and to determine the presence of bowel sounds. The dressing is inspected and changed as needed. Drain output, fluid balance, postoperative laboratory values are reviewed and blood transfusion is ordered if needed. Postoperative X-rays are reviewed showing the alignment of the spine and position of the bone graft. Transfer orders are written and a physiotherapy consultation request. A note is written and the family is met in the waiting room and questions answered. The referring physician is contacted and informed about the results of surgery.

Daily visits are made while on the hospital floor; notes are written to document the patient's progress. The drainage tube and the Foley catheter are removed when appropriate, and the wound is inspected and the dressing changed. Activity parameters are modified to advance the patient's ambulation and mobility. The patient's diet is advanced as tolerated.

Questions from the physiotherapy staff are answered. The hospital orthotist is consulted for fabrication of a thoracolumbar orthosis. Appropriate pain medications are ordered as PO intake advances. Orders are written for outpatient physiotherapy visits after discharge. Discharge planning and coordination occurs with the physician, home health agencies and the patient and family.

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

### SURVEY DATA

<b>Presenter(s):</b>	John Wilson, MD (AANS); Charles Mick, MD (NASS)				
<b>Specialty(s):</b>	American Association of Neurological Surgeons; Congress of Neurological Surgeons; North American Spine Society				
<b>CPT Code:</b>	22532				
<b>Sample Size:</b>	70	<b>Resp n:</b>	27	<b>Resp %:</b>	39%
<b>Sample Type:</b>	Panel - spine surgeons most likely familiar with procedure. Less than 30 response – new technique/low frequency.				
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		23.00	24.00	25.00	28.75
<b>Pre-Service Evaluation Time:</b>				60	
<b>Pre-Service Positioning Time:</b>				30	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				30	
<b>Intra-Service Time:</b>		120	150	170	180
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b>30</b>				
<b>Critical Care time/visit(s):</b>	<b>0</b>				
<b>Other Hospital time/visit(s):</b>	<b>117</b>	<b>99232x2 99231x3</b>			
<b>Discharge Day Mgmt:</b>	<b>36</b>	<b>99238</b>			
<b>Office time/visit(s):</b>	<b>84</b>	<b>99213x3 99212x1</b>			

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30), 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
22556	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	23.46	90

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

	Svy CPT 22532	Ref CPT 22556
<b>TIME ESTIMATES (MEDIAN)</b>		
Pre-service	120	85
Intra-service	170	180
Same Day Immediate Post-service	30	168
Critical care	0	
Other hospital visit	117	
Discharge day management	36	
Office visit	84	92
<b>TOTAL TIME</b>	557	525

**INTENSITY/COMPLEXITY MEASURES (mean)****TIME SEGMENTS**

Pre-service	3.91	3.90
Intra-service	4.14	3.95
Post-service	3.59	3.62

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	3.86	3.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.86	3.81
Urgency of medical decision making	3.36	3.38

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	4.29	3.95
Physical effort required	4.14	3.95

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	4.14	4.00
Outcome depends on the skill and judgment of physician	4.45	4.38
Estimated risk of malpractice suit with poor outcome	4.36	4.29

**ADDITIONAL RATIONALE**

CPT 22556 describes an anterolateral thoracic interbody fusion using a thoracotomy approach. The lateral extracavitary approach (new code 22532) requires significantly more muscle dissection of spinal/paraspinal tissues as well as rib removal, but has a more limited visual exposure of the anterolateral spine and spinal cord. Patients undergoing the lateral extracavitary approach often have pulmonary disease that precludes open thoracotomy, and are typically older patients with more medical co-morbidities. Survey respondents report a higher level of acuity in the first two postoperative hospital visits. Although the intraservice time by the respondents is less, the survey respondents reported slightly higher intensity measures and they represent a subspecialty group with specific training in this unusual procedure compared with the larger random-survey respondents that provided comparative data for 22556. Moreover, neurosurgeons more commonly perform this procedure and reported longer intraservice times than the overall median time. The 25<sup>th</sup> percentile RVW of 24.00 is recommended for 22532, since this fairly balances the higher intensity intraservice component with lower intraservice time but higher pre and postservice times.



CPT Code: 22533

Tracking No: J2

Global: 090

Recommended RVW: 23.12

**Descriptor:** Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar

---

**SURVEY Vignette (Typical Patient)**

A 57-year-old woman presents with progressive thoracolumbar spine pain and normal lower extremity strength and sensation. Plain X-rays showed an L1-L2 severely degenerated disk space with anterior translation of the vertebral body, kyphosis, and collapse of the disk space height. An MRI scan showed a broad disk protrusion at L1-L2 without significant compression of the spinal cord and advanced degenerative changes of the end plates and ligaments. At operation, an arthrodesis is performed using a lateral extracavitary approach. Postoperative hospital care and office visits are conducted as necessary through the 90-day global.

---

**Clinical Description Of Service:**

**Pre service work:**

The medical record is reviewed to ensure that the patient is stable for the planned surgical procedure. The radiographic studies are reviewed showing the bone injury and the compression of the spinal cord. Radiographic findings are correlated with the clinical exam and the surgical plan is confirmed. The surgical decompression of the spinal cord with lateral extracavitary discectomy will require placement interbody bone graft for anterior arthrodesis and reconstruction of the spine. The surgeon confers with the patient and family; explaining the current condition and the need for surgical intervention. Questions are answered, consent obtained and a note written in the record. He confers with the Anesthesiologist and the Operating Room to review positioning, the intraoperative plan and equipment needs. After the patient is anesthetized, she is log-rolled and positioned on the operative table. The surgical site is prepped and draped into a sterile field.

**Intraservice work:**

A midline incision is made with an inferior curve out laterally to allow exposure of the paraspinal muscle bundle, centered over the fractured segment. The paraspinal muscles are elevated from the spinous processes and laminae with the electrocautery unit. The right side paraspinal muscle bundle is then divided laterally and elevated off the ribs allowing for retraction towards the midline. Intraoperative imaging is used to correctly identify the L1-L2 interspace and the T12 rib is dissected from the intercostal muscles and underlying pleura bluntly to avoid pneumothorax. The T12 rib is resected from the posterior bend to the costovertebral junction in a single piece. The intercostal nerve is identified and traced back to the neural foramen. The associated transverse process, lateral portion of the facet and pedicle of L2 are removed with the high-speed drill exposing the lateral aspect of the dural sac and the dorsolateral aspect of the vertebral body. The peritoneal sac is gently depressed with a dampened sponge and retracted, exposing the lateral surface of the vertebral body. The nerve root is gently retracted superiorly to allow visualization of the posterior cortical margin of the vertebral body. A variety of curettes and pituitary rongeurs are used to remove the degenerated L1-L2 disc material from the space. The cartilage is scraped from the vertebral endplates and the bone is then decorticated with the high-speed drill. Structural bone graft (graft harvest reported separately) is tapped into position between the endplates under direct vision for interbody arthrodesis. Extreme care is used to avoid compression of the spinal cord. If clinically indicated, spinal instrumentation is inserted (reported separately). A drain is placed in the deep space and a multilayer closure is undertaken.

**Post-service work:**

Dressings are applied. The patient is rolled onto a recovery bed and examination shows him to be moving his legs equivalent to preop. A chest radiograph is obtained to evaluate for a pneumothorax. Orders are written and a note is dictated. The surgeon maintains contact with ICU staff with respect to neuro checks. Orders are given for IV fluids and narcotic analgesics. During the hospitalization, the patient is examined for neurologic function and to determine the presence of bowel sounds. The dressing is inspected and changed as needed. Drain output, fluid balance, postoperative laboratory values are reviewed and blood transfusion is ordered if needed. Postoperative X-rays are reviewed showing the alignment of the spine and position of the bone graft. Transfer orders are written and a physiotherapy consultation request. A note is written and the family is met in the waiting room and questions answered. The referring physician is contacted and informed about the results of surgery.

Daily visits are made while on the hospital floor; notes are written to document the patient's progress. The drainage tube and the Foley catheter are removed when appropriate, and the wound is inspected and the dressing changed. Activity parameters are modified to advance the patient's ambulation and mobility. The patients diet is advanced as tolerated. Questions from the physiotherapy staff are answered. The hospital orthotist is consulted for fabrication of a thoracolumbar orthosis. Appropriate pain medications are ordered as PO intake advances. Orders are written for outpatient physiotherapy visits after discharge. Discharge planning and coordination occurs with the physician, home health agencies and the patient and family.

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

### SURVEY DATA

<b>Presenter(s):</b>	John Wilson, MD (AANS); Charles Mick, MD (NASS)					
<b>Specialty(s):</b>	American Association of Neurological Surgeons; Congress of Neurological Surgeons; North American Spine Society					
<b>CPT Code:</b>	22533					
<b>Sample Size:</b>	70	<b>Resp n:</b>	27	<b>Resp %:</b>	39%	
<b>Sample Type:</b>	Panel - spine surgeons most likely familiar with procedure. Less than 30 response – new technique/low frequency.					
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		20.00	23.12	25.00	26.75	35.00
<b>Pre-Service Evaluation Time:</b>				58		
<b>Pre-Service Positioning Time:</b>				28		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				30		
<b>Intra-Service Time:</b>		120	150	180	180	300
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	30					
<b>Critical Care time/visit(s):</b>	0					
<b>Other Hospital time/visit(s):</b>	87	99232x1 99231x3				
<b>Discharge Day Mgmt:</b>	36	99238				
<b>Office time/visit(s):</b>	84	99213x3 99212x1				

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23), 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	22.28	90

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

<b>TIME ESTIMATES (MEDIAN)</b>	Svy CPT	Ref CPT
	22533	22558
Pre-service	115	80
Intra-service	180	180
Same Day Immediate Post-service	30	150
Critical care	0	
Other hospital visit	87	
Discharge day management	36	
Office visit	84	92
<b>TOTAL TIME</b>	532	502

**INTENSITY/COMPLEXITY MEASURES (mean)****TIME SEGMENTS**

Pre-service	3.64	3.60
Intra-service	3.93	3.67
Post-service	3.29	3.27

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	3.67	3.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.73	3.60
Urgency of medical decision making	3.20	3.20

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	4.00	3.67
Physical effort required	4.00	3.93

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	4.00	4.07
Outcome depends on the skill and judgment of physician	4.33	4.27
Estimated risk of malpractice suit with poor outcome	4.13	4.07

**ADDITIONAL RATIONALE**

CPT 22558 describes an anterolateral interbody fusion using an approach through the abdomen or retroperitoneum.

The lateral extracavitary approach (new code 22533) requires significantly more muscle dissection of spinal/paraspinal tissues as well as rib removal, but has a more limited visual exposure of the anterolateral spine and spinal cord. Patients undergoing the lateral extracavitary approach often have abdominal disease that precludes open laparotomy, and are typically older patients with more medical co-morbidities. Survey respondents report a higher level of acuity in the first two postoperative hospital visits. Although the intraservice time by the respondents is slightly less, the survey respondents reported slightly higher intensity measures and they represent a subspecialty group with specific training in this unusual procedure compared with the larger random-survey respondents that provided comparative data for 22558. Moreover, neurosurgeons more commonly perform this procedure and reported longer intraservice times than the overall median time. The 25<sup>th</sup> percentile RVW of 23.12 is recommended for 22533, since this fairly balances the higher intensity intraservice component with lower intraservice time but higher pre and postservice times.

**Services Reported with Multiple CPT Codes**

1. Is this new/revised code typically reported on the same date with other CPT codes? **Yes**

630X2 Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments), lumbar, single segment  
**22533 Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); lumbar**

225X3 Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional interspace

22845 Anterior instrumentation, 2 to 3 vertebral segments

20936 Autograft for spine surgery only (includes harvesting the graft), local (eg, ribs, spinous process, or laminae fragments) obtained from same incision

or

20938 Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision)

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

X Multiple codes are used to maintain consistency with similar codes.

X Historical precedents.

3. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes.

	CPT	global	multi	RVW	Pre	Intra	Post	Total
1.	630X2	90	100%	32.00	130	205	296	631
2.	22533	90	50%	23.12	115	180	237	532
3.	225X3	ZZZ	100%	6.00	0	60	0	60
4.	22845	ZZZ	100%	11.96	0	90	0	90
5a	20936	XXX	100%	0.00	0	0	0	0
				<b>61.52</b>				<b>1,047</b>
<b>OR</b>								
5b.	20938	ZZZ	100%	3.02	0	45	0	45
				<b>64.54</b>				<b>1,092</b>

**FREQUENCY INFORMATION**

**How was this service previously reported?**

22899 Unlisted procedure, spine

Or –rarely - (although not accurate for the procedures):

22558 Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare the interspace (other than for decompression): lumbar

**How often do physicians in your specialty perform this service?**

Specialty: Neurosurgery/Orthopaedic Surgery                      Commonly ——— Sometimes                      **Rarely**

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period?**

Specialty: Neurosurgery/Orthopaedic Surgery                      Frequency: 400 (primarily NS)

**For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?**

Specialty: Neurosurgery/Orthopaedic Surgery                      Frequency: 250 (primarily NS)

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

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

(Feb. 2003)

**CPT Code: 22534      Tracking No: J3      Global: ZZZ      Recommended RVW: 6.00**

**Descriptor:** Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional interspace (List separately in addition to code for primary procedure)

**SURVEY Vignette (Typical Patient)**

A 63-year-old man presents with progressive thoracic spine pain and normal lower extremity strength and sensation. Plain X-rays showed T10-T11 and T9-10 degenerated disk spaces, anterior translation of the vertebral bodies, and collapse of the disk space height. An MRI scan showed a broad disk protrusion at T10-T11 and T9-T10 without significant compression of the spinal cord and advanced degenerative changes of the end plates and ligaments. At operation, an arthrodesis is performed using a lateral extracavitary approach. [NOTE – THIS IS AN ADD-ON CODE: For this survey only consider the additional physician work for the additional level arthrodesis. The exposure, arthrodesis, and followup visits related to the T10-T11 interspace will be reported using the primary procedure code 225X1 which has a 90-day global period.]

**Clinical Description Of Service:**

**Intraservice work:** Utilizing the existing midline curvilinear incision, the elevation of the paraspinous muscle bundle is extended and addition segment superiorly to expose the T9-10 segment in addition to the T10-11 segment. The associated T10rib is dissected from the intercostal muscles and underlying pleura bluntly to avoid pneumothorax. The T10 rib is resected from the posterior bend to the costovertebral junction in a single piece. The intercostal nerve is identified and traced back to the neural foramina. The associated transverse process, lateral portion of the facet and pedicle are removed with the high-speed drill exposing the lateral aspect of the dural sac and the dorsolateral aspect of the vertebral body. The parietal pleura is gently depressed with a dampened sponge and retracted, exposing the lateral surface of the vertebral body. The nerve root may be divided orgently retracted superiorly to allow visualization of the posterior cortical margin of the vertebral body. A variety of curettes and pituitary rongeurs are used to remove the degenerated T9-10 disc material from the space. The cartilage is scraped from the vertebral endplates and the bone is then decorticated with the high-speed drill. A structural bone graft(harvest reported separately) is tapped into position between the endplates of the additional space under direct vision for interbody arthrodesis. Extreme care is used to avoid compression of the spinal cord. If clinically indicated, spinal instrumentation is inserted and reported separately.

**SURVEY DATA**

<b>Presenter(s):</b>	John Wilson, MD (AANS); Charles Mick, MD (NASS)				
<b>Specialty(s):</b>	AANS/CNS; NASS				
<b>CPT Code:</b>	22534				
<b>Sample Size:</b>	70	<b>Resp n:</b>	27	<b>Resp %:</b>	39%
<b>Sample Type:</b>	Panel - spine surgeons most likely familiar with procedure. Less than 30 response – new technique/low frequency.				
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		3.50	5.53	6.00	8.00
<b>Pre-Service Evaluation Time:</b>				0	
<b>Pre-Service Positioning Time:</b>				0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0	
<b>Intra-Service Time:</b>		45	49	60	120
<b>Post-Service</b>	<b>Total Min</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	0				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	0				
<b>Office time/visit(s):</b>	0				

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)	5.53	ZZZ

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

<b>TIME ESTIMATES (MEDIAN)</b>	Svy CPT 22534	Ref CPT 22585
Pre-service	0	0
Intra-service	60	45
Same Day Immediate Post-service	0	0
Critical care	0	0
Other hospital visit	0	0
Discharge day management	0	0
Office visit	0	0
<b>TOTAL TIME</b>	60	45

**INTENSITY/COMPLEXITY MEASURES (mean)****TIME SEGMENTS**

Pre-service	n/a	n/a
Intra-service	4.05	3.70
Post-service	n/a	n/a

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	3.55	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.55	3.40
Urgency of medical decision making	3.23	3.25

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	4.27	3.90
Physical effort required	4.18	4.05

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	4.27	4.10
Outcome depends on the skill and judgment of physician	4.41	4.30
Estimated risk of malpractice suit with poor outcome	4.23	4.10

**ADDITIONAL RATIONALE**

CPT 22585 describes an additional thoracic or lumbar anterolateral interbody fusion. The lateral extracavitary approach (new code 22534) requires significantly more muscle dissection of spinal/paraspinal tissues as well as rib removal, but has a more limited visual exposure of the anterolateral spine and spinal cord. Once a thoracotomy or laparotomy is performed, the exposure of an additional level requires mobilizing an additional segmental vessel within the same opening and closure. In comparison, exposure of an additional level in the lateral extracavitary approach requires another rib resection and larger closure in addition to mobilizing an additional segmental vessel. The respondents describe a third more intraservice time, supporting the higher work value reflected in the median survey result compared with the reference service. The median RVW of 6.00 is recommended for 22534.

**Services Reported with Multiple CPT Codes**

1. Is this new/revised code typically reported on the same date with other CPT codes? **Yes**

Variable - See Summary Forms for 630x1 630x2 225x1 225x2

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

X Multiple codes are used to maintain consistency with similar codes.  
X Historical precedents.

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

Variable - See Summary Forms for 630x1 630x2 225x1 22534

**FREQUENCY INFORMATION**

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

22899 Unlisted procedure, spine

Or –rarely - (although not accurate for the procedures):

22585 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare the interspace (other than for decompression): each additional interspace (list separately in addition to code for primary procedure)

**How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Neurosurgery/Orthopaedic Surgery                      Commonly                      Sometimes                      Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Neurosurgery/Orthopaedic Surgery                      Frequency: 350 (primarily NS)

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

Specialty: Neurosurgery/Orthopaedic Surgery                      Frequency: 250 (primarily NS)

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

CPT Code: 63101

Tracking No: J4

Global: 090

Recommended RVW: 32.00

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

---

**SURVEY Vignette (Typical Patient)**

A 58-year-old man presents with a past history of prostate of cancer, a six- week history of progressive thoracolumbar spine pain, a moderate kyphotic deformity over the thoracolumbar junction with tenderness to palpation, and recent bilateral leg weakness and numbness requiring a cane for ambulation. He has proximal lower extremity weakness and a relative sensory loss is below the T11 level. Plain X-rays showed a T11 destructive lesion with pathologic compression fracture with kyphotic angulation of the spine and 60% loss of vertebral body height. MRI scan showed retropulsion of bone fragments and soft tissue mass in the spinal canal consistent with tumor. There is also tumor extending into the posterior elements. At operation, a thoracic vertebral corpectomy is performed using a lateral extracavitary approach. Postoperative hospital care and office visits are conducted as necessary through the 90-day global. [NOTE: When completing this survey, do not consider your time/work to perform arthrodesis/instrumentation, which would be reported/billed separately.]

---

**Clinical Description Of Service:**

**Pre service work:**

The medical record is reviewed to ensure that the patient is stable for the planned surgical procedure. The radiographic studies are reviewed showing the tumor and the compression of the spinal cord. Radiographic findings are correlated with the clinical exam and the surgical plan is confirmed. The surgeon confers with the patient and family; explaining the current condition and the need for surgical intervention. Phone conference with the medical oncologist confirms the patient's stable condition medically and life expectancy. Questions are answered, consent obtained and a note written in the record. He confers with the anesthesiologist and the operating room to review positioning, the intraoperative plan and equipment needs. After the patient is anesthetized, he is log-rolled and positioned with great care to avoid further loss of spinal alignment. The surgical site is prepped and draped into a sterile field.

**Intraservice work:**

A midline incision is made with an inferior curve out laterally to allow exposure of the paraspinous muscle bundle, centered over the fractured segment. The paraspinous muscles are elevated from the spinous processes and laminae with the electrocautery unit. The right side paraspinous muscle bundle is then divided laterally and elevated off the ribs allowing for retraction towards the midline. Intraoperative imaging is used to correctly identify the tumor at T11 vertebral body and the associated T11 and T12 ribs are dissected from the intercostal muscles and underlying pleura bluntly to avoid pneumothorax. The ribs are resected from the posterior bend to the costovertebral junction in a single pieces. The intercostal nerves are identified and traced back to the neural foramina. The associated transverse process(es), lateral portion of the facet(s) and pedicle(s) are removed with the high-speed drill exposing the lateral aspect of the dural sac and the lateral aspect of the vertebral body. The parietal pleura is gently depressed with a dampened sponge and retracted, exposing the lateral surface of the T 11 vertebral body. The T11 nerve root may be divided or gently retracted superiorly to allow visualization of the posterior cortical margin. A high-speed drill is then used to remove the central portion of the vertebral body and exposing the superior, inferior, and posterior cortical margins. A curette is used to deliver the retropulsed bone fragments and tumor mass away from the spinal cord. The T11-12 and T12-L1 discs are removed with curettes and pituitary rongeurs exposing the endplates of T11 and L1. The exposed surfaces of the thecal sac are carefully examined for dural tears. Hemostasis in the epidural space is obtained. (As clinically indicated, an intervertebral fusion or intervertebral body reconstruction is performed and reported separately.) A drain is placed in the deep space and a multilayer closure is undertaken.

**Post-service work:**

Dressings are applied and the patient is rolled onto a recovery bed and examination shows him to be moving his legs equivalent to preop. Orders are written and a note is dictated. A chest radiograph is obtained and reviewed to determine if a pneumothorax is present. The surgeon maintains contact with ICU staff with respect to neuro checks. Orders are given for IV fluids and narcotic analgesics. During the postoperative hospitalization, the patient is examined for neurologic function and to determine the presence of bowel sounds. The dressing is inspected and changed as needed. Drain output, fluid balance, postoperative laboratory values are reviewed and blood transfusion is ordered if needed. Postoperative X-

rays are reviewed showing the alignment of the spine. Transfer orders are written and a physiotherapy consultation request. A note is written and the family is met in the waiting room and questions answered. The referring physician is contacted and informed about the results of surgery. Daily visits are made while on the hospital floor. The drain tube and the Foley catheter are removed when appropriate, and the wound is inspected and the dressing changed. Activity parameters are modified to advance the patient's ambulation and mobility. The patient's diet is advanced as tolerated. Questions from the physiotherapy staff are answered. Daily notes are written documenting the in-hospital progress. Orders are written for outpatient physiotherapy visits after discharge.

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

### SURVEY DATA

<b>Presenter(s):</b>	John Wilson, MD (AANS); Charles Mick, MD (NASS)					
<b>Specialty(s):</b>	American Association of Neurological Surgeons; Congress of Neurological Surgeons; North American Spine Society					
<b>CPT Code:</b>	63101					
<b>Sample Size:</b>	70	<b>Resp n:</b>	27	<b>Resp %:</b>	39%	
<b>Sample Type:</b>	Panel - spine surgeons most likely familiar with procedure. Less than 30 response – new technique/low frequency.					
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		24.00	29.10	32.00	40.00	45.00
<b>Pre-Service Evaluation Time:</b>				70		
<b>Pre-Service Positioning Time:</b>				30		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				30		
<b>Intra-Service Time:</b>		120	180	215	245	360
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	43					
<b>Critical Care time/visit(s):</b>	30	99232*x1				
<b>Other Hospital time/visit(s):</b>	106	99232x1 99231x4				
<b>Discharge Day Mgmt:</b>	36	99238				
<b>Office time/visit(s):</b>	84	99213x3 99212x1				

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41), 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
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	35.57	90

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

	Svy CPT 63101	Ref CPT 63087
<b>TIME ESTIMATES (MEDIAN)</b>		
Pre-service	130	105
Intra-service	215	265
Same Day Immediate Post-service	43	45
Critical care	30	0
Other hospital visit	106	144
Discharge day management	36	36
Office visit	84	69
<b>TOTAL TIME</b>	<b>644</b>	<b>664</b>

**INTENSITY/COMPLEXITY MEASURES (mean)****TIME SEGMENTS**

Pre-service	4.33	4.17
Intra-service	4.67	4.50
Post-service	3.92	3.83

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	4.36	4.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	4.33
Urgency of medical decision making	4.42	4.42

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	4.83	4.50
Physical effort required	4.83	4.50

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	4.83	4.58
Outcome depends on the skill and judgment of physician	4.92	4.58
Estimated risk of malpractice suit with poor outcome	4.75	4.67

**ADDITIONAL RATIONALE**

CPT 63087 describes an anterolateral thoracolumbar approach for a vertebrectomy. The lateral extracavitary approach (63101) requires significantly more muscle dissection of spinal/paraspinal tissues as well as rib removal, but has a more limited visual exposure of the anterolateral spine and spinal cord. Patients undergoing the lateral extracavitary approach often have pulmonary disease that precludes open thoracotomy, and are typically older patients with more medical co-morbidities. Survey respondents report a higher level of acuity in the first two postoperative hospital visits. However, the intraservice time by the respondents is less, likely reflecting the absence of diaphragm take-down and closure reflected in 63087. The median survey RVW of 32.00 is recommended for 63101. This is less than the reference service physician work value and fairly balances the slightly higher intensity intraservice component with lower intraservice time.



CPT Code: 63102

Tracking No: J5

Global: 090

Recommended RVW: 32.00

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

---

**SURVEY Vignette (Typical Patient)**

A 58-year-old man presents with a past history of prostate of cancer, a six-week history of progressive lumbar spine pain, with tenderness to palpation, and recent bilateral leg weakness and numbness requiring a cane for ambulation. He has proximal lower extremity weakness and a relative sensory loss is below the L3 level. Plain X-rays showed an L3 destructive lesion with pathologic compression fracture with kyphotic angulation of the spine and 60% loss of vertebral body height. MRI scan showed retropulsion of bone fragments and soft tissue mass in the spinal canal consistent with tumor. There is also tumor extending into the posterior elements. At operation, a lumbar vertebral corpectomy is performed using a lateral extracavitary approach. Postoperative hospital care and office visits are conducted as necessary through the 90-day global. [NOTE: When completing this survey, do not consider your time/work to perform arthrodesis/instrumentation, which would be reported/billed separately.]

---

**Clinical Description Of Service:**

**Pre service work:**

The medical record is reviewed to ensure that the patient is stable for the planned surgical procedure. The radiographic studies are reviewed showing the bone injury and the compression of the spinal cord. Radiographic findings are correlated with the clinical exam and the surgical plan is confirmed. The surgeon confers with the patient and family; explaining the current condition and the need for surgical intervention. Questions are answered, consent obtained and a note written in the record. The surgeon confers with the anesthesiologist and the operating room to review positioning, the intraoperative plan and equipment needs. After the patient is anesthetized, he is log-rolled and positioned with great care to avoid further loss of spinal alignment. The surgical site is prepped and draped into a sterile field.

**Intraservice work:**

A midline incision is made with an inferior curve out laterally to allow exposure of the paraspinous muscle bundle, centered over the fractured segment. The paraspinous muscles are elevated from the spinous processes and laminae with the electrocautery unit. The right side paraspinous muscle bundle is then divided laterally and elevated off the ribs allowing for retraction towards the midline. Intraoperative imaging is used to correctly identify the tumor at L1 vertebral body and the associated rib T12 is dissected from the intercostal muscles and underlying pleura and diaphragm bluntly to avoid pneumothorax. The rib is resected from the posterior bend to the costovertebral junction in a single piece. The intercostal nerve is identified and traced back to the neural foramen. The associated transverse process, lateral portion of the facet and pedicle are removed with the high-speed drill exposing the lateral aspect of the dural sac and the dorsolateral aspect of the vertebral body. The parietal pleura is gently depressed with a dampened sponge and retracted, exposing the lateral surface of the L1 vertebral body. The nerve root may be divided or gently retracted superiorly to allow visualization of the posterior cortical margin. A high-speed drill is then used to remove the central portion of the vertebral body and exposing the superior, inferior, and posterior cortical margins. A curette is used to deliver the retropulsed bone fragments and tumor mass away from the spinal cord. The T12-L1 and L1-L2 discs are removed with curettes and pituitary rongeurs exposing the endplates of T12 and L2. The exposed surfaces of the thecal sac are carefully examined for dural tears. Hemostasis in the epidural space is obtained. (As clinically indicated, intervertebral fusion, spinal instrumentation or vertebral body reconstruction is performed and reported separately.) A drain is placed in the deep space and a multilayer closure is undertaken.

**Post-service work:**

Dressings are applied and the patient is rolled onto a recovery bed and examination shows him to be moving his legs equivalent to preop. A chest radiograph is obtained to determine if a pneumothorax is present. Orders are written and a note is dictated. The surgeon maintains contact with ICU staff with respect to neuro checks. Orders are given for IV fluids and narcotic analgesics. During the hospitalization, the patient is examined for neurologic function and to determine the presence of bowel sounds. The dressing is inspected and changed as needed. Drain output, fluid balance, postoperative laboratory values are reviewed and blood transfusion is ordered if needed. Postoperative X-rays are reviewed showing the alignment of the spine. Transfer orders are written and a physiotherapy consultation request. A note is written and the

family is met in the waiting room and questions answered. The referring physician is contacted and informed about the results of surgery.

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

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

### SURVEY DATA

<b>Presenter(s):</b>	John Wilson, MD (AANS); Charles Mick, MD (NASS)				
<b>Specialty(s):</b>	American Association of Neurological Surgeons; Congress of Neurological Surgeons; North American Spine Society				
<b>CPT Code:</b>	63102				
<b>Sample Size:</b>	70	<b>Resp n:</b>	27	<b>Resp %:</b>	39%
<b>Sample Type:</b>	Panel - spine surgeons most likely familiar with procedure. Less than 30 response – new technique/low frequency.				
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		26.50	30.00	32.00	36.00
<b>Pre-Service Evaluation Time:</b>				70	
<b>Pre-Service Positioning Time:</b>				30	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				30	
<b>Intra-Service Time:</b>		130	180	205	250
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	40				
<b>Critical Care time/visit(s):</b>	30	99232*x1			
<b>Other Hospital time/visit(s):</b>	106	99232x1 99231x4			
<b>Discharge Day Mgmt:</b>	36	99238			
<b>Office time/visit(s):</b>	84	99213x3 99212x1			

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
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	35.57	90

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

<b>TIME ESTIMATES (MEDIAN)</b>	Svy CPT 63102	Ref CPT 63087
Pre-service	130	105
Intra-service	205	265
Same Day Immediate Post-service	40	45
Critical care	30	0
Other hospital visit	106	144
Discharge day management	36	36
Office visit	84	69
<b>TOTAL TIME</b>	<b>631</b>	<b>664</b>

**INTENSITY/COMPLEXITY MEASURES (mean)****TIME SEGMENTS**

Pre-service	4.00	4.17
Intra-service	4.67	4.50
Post-service	3.75	3.83

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.31	4.33
Urgency of medical decision making	3.92	4.42

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	4.67	4.50
Physical effort required	4.67	4.50

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	4.62	4.58
Outcome depends on the skill and judgment of physician	4.77	4.58
Estimated risk of malpractice suit with poor outcome	4.38	4.67

**ADDITIONAL RATIONALE**

CPT 63087 describes an anterolateral thoracolumbar approach for a vertebrectomy. The lateral extracavitary approach (63102) requires significantly more muscle dissection of spinal/paraspinal tissues as well as rib removal, but has a more limited visual exposure of the anterolateral spine and spinal cord. Patients undergoing the lateral extracavitary approach often have abdominal and pulmonary disease that precludes open thoracotomy or laparotomy, and are typically older patients with more medical co-morbidities. Survey respondents report a higher level of acuity in the first two postoperative hospital visits. However, the intraservice time by the respondents is less, likely reflecting the absence of diaphragm take-down and closure reflected in 63087. The median survey RVW of 32.00 is recommended for 63102. This is less than the reference service work value and fairly balances the slightly higher intensity intraservice component with lower intraservice time.



CPT Code: 63103

Tracking No: J6

Global: ZZZ

Recommended RVW: 5.00

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

---

**SURVEY Vignette (Typical Patient)**

A 58-year-old man presents with a past history of prostate of cancer, a six- week history of progressive thoracolumbar spine pain, a moderate kyphotic deformity over the thoracolumbar junction with tenderness to palpation, and recent bilateral leg weakness and numbness requiring a cane for ambulation. He has proximal lower extremity weakness and a relative sensory loss is below the T11 level. Plain X-rays showed a T10 and T11 destructive lesion with pathologic compression fracture at these levels with kyphotic angulation of the spine and loss of vertebral body height. MRI scan showed retropulsion of bone fragments and soft tissue mass in the spinal canal consistent with tumor extending over the two involved segments. There is also tumor extending into the posterior elements. At operation, a thoracic vertebral corpectomy of two vertebral segments is performed using a lateral extracavitary approach. [NOTE – THIS IS AN ADD-ON CODE: For this survey only consider the additional physician work for the additional level vertebrectomy. The exposure, resection, and followup visits related to the T11 vertebral body will be reported using the primary procedure code 630X1 which has a 90-day global period.]

---

**Clinical Description Of Service:**

**Intraservice work:**

Utilizing the existing midline curvilinear incision, the elevation of the paraspinous muscle bundle is extended rostrally to expose the T10 segment in addition to the T11 segment. The T10 rib is dissected free from the intercostals muscles and resected from the posterior bend to the costovertebral junction in a single piece. The intercostal nerve is identified and traced back to the neural foramen. The associated transverse process, lateral portion of the facet and pedicle are removed with the high-speed drill exposing the lateral aspect of the dural sac and the dorsolateral aspect of the vertebral bodies. The parietal pleura is gently depressed with a dampened sponge and retracted, exposing the lateral surface of the T10 vertebral body. The 10 nerve root may be divided or gently retracted superiorly to allow visualization of the posterior cortical margin. A high-speed drill is then used to remove the central portion of the vertebral body and exposing the superior, inferior, and posterior cortical margins. A curette is used to deliver the retropulsed bone fragments and tumor mass away form the spinal cord. The T9-T10, T10-T11 discs are removed with curettes and pituitary rongeurs exposing the endplate of T9. The exposed surfaces of the thecal sac are carefully examined for dural tears. (As clinically indicated, intervertebral fusion or vertebral body reconstruction is performed and reported separately.)

**SURVEY DATA**

<b>Presenter(s):</b>	John Wilson, MD (AANS); Charles Mick, MD (NASS)				
<b>Specialty(s):</b>	American Association of Neurological Surgeons; Congress of Neurological Surgeons; North American Spine Society				
<b>CPT Code:</b>	63103				
<b>Sample Size:</b>	70	<b>Resp n:</b>	27	<b>Resp %:</b>	39%
<b>Sample Type:</b>	Panel - spine surgeons most likely familiar with procedure. Less than 30 response – new technique/low frequency.				
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		3.00	4.00	5.00	5.52
<b>Pre-Service Evaluation Time:</b>				0	
<b>Pre-Service Positioning Time:</b>				0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0	
<b>Intra-Service Time:</b>		45	60	60	90
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	0				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	0				
<b>Office time/visit(s):</b>	0				

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
63088	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; each additional segment (List separately in addition to code for primary procedure)	4.33	ZZZ

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

<b>TIME ESTIMATES (MEDIAN)</b>	Svy CPT 63103	Ref CPT 63088
Pre-service	0	0
Intra-service	60	67
Same Day Immediate Post-service	0	0
Critical care	0	0
Other hospital visit	0	0
Discharge day management	0	0
Office visit	0	0
<b>TOTAL TIME</b>	60	67

**INTENSITY/COMPLEXITY MEASURES (mean)****TIME SEGMENTS**

Pre-service	n/a	n/a
Intra-service	4.60	4.33
Post-service	n/a	n/a

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	4.36	4.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.14	4.14
Urgency of medical decision making	4.43	4.43

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	4.71	4.43
Physical effort required	4.79	4.43

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	4.79	4.50
Outcome depends on the skill and judgment of physician	4.71	4.43
Estimated risk of malpractice suit with poor outcome	4.50	4.36

**ADDITIONAL RATIONALE**

CPT 63088 describes an additional thoracic or lumbar anterolateral interbody fusion. The lateral extracavitary approach (63103) requires significantly more muscle dissection of spinal/paraspinal tissues as well as rib removal, but has a more limited visual exposure of the anterolateral spine and spinal cord. Once a thoracotomy or laparotomy is performed, the exposure of an additional level requires mobilizing an additional segmental vessel within the same opening and closure. In comparison, exposure of an additional level in the lateral extracavitary approach requires another rib resection and larger closure in addition to mobilizing an additional segmental vessel. The respondents describe similar intraservice time. Moreover, neurosurgeons more commonly perform this procedure and reported longer intraservice times than the overall median time. This supports the higher work value reflected in the median survey result compared with the reference service. The survey median RVW of 5.00 is recommended for 63103.

**Services Reported with Multiple CPT Codes**

1. Is this new/revised code typically reported on the same date with other CPT codes? **Yes**

Thoracic: 630x1 + **63103** + 225x1 + 2 25x3(x2) + 22846 + 20936or20938

OR

Lumbar: 630x2 + **63103** + 225x2 + 2 25x3(x2) + 22846 + 20936or20938

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

X Multiple codes are used to maintain consistency with similar codes.

X Historical precedents.

3. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes.

Typically Two Levels if 63103 is Reported

	CPT	global	multi	RVW	Pre	Intra	Post	Total
1.	630X1	90	100%	32.00	130	215	299	644
2.	225X1	90	50%	24.00	120	170	267	557
3.	22846	ZZZ	100%	12.42	0	120	0	120
4.	225X3x2	ZZZ	100%	6.00x2	0	60	0	60x2
5.	<b>63103</b>	ZZZ	100%	5.00	0	60	0	60
6a.	20936	XXX	100%	0.00	0	0	0	0
				<b>73.42</b>				<b>1,223</b>
<b>OR</b>								
6b.	20938	ZZZ	100%	3.02	0	45	0	45
				<b>76.44</b>				<b>1,268</b>

OR

	CPT	global	multi	RVW	Pre	Intra	Post	Total
1.	630X2	90	100%	32.00	130	205	296	631
2.	225X2	90	50%	23.12	115	180	237	532
3.	22846	ZZZ	100%	12.42	0	120	0	120
4.	225X3x2	ZZZ	100%	6.00x2	0	60	0	60x2
5.	<b>63103</b>	ZZZ	100%	5.00	0	60	0	60
6a.	20936	XXX	100%	0.00	0	0	0	0
				<b>72.98</b>				<b>1,197</b>
<b>OR</b>								
6b.	20938	ZZZ	100%	3.02	0	45	0	45
				<b>76.00</b>				<b>1,242</b>

**FREQUENCY INFORMATION**

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

64999 Unlisted procedure, nervous system

Or –rarely - (although not accurate for the procedures):

63066 Costovertebral approach with decompression of spinal cord or nerve root(s) (eg herniated intervertebral disc), thoracic, each additional segment

**How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Neurosurgery/Orthopaedic Surgery

Commonly — Sometimes

Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Neurosurgery/Orthopaedic Surgery

Frequency: 35 (primarily NS)

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

Specialty: Neurosurgery/Orthopaedic Surgery

Frequency: 20 (primarily NS)

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

---

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
090 Day Global Period  
Facility Direct Inputs**

<b>CPT</b>	<b>DESCRIPTION</b>	<b>GLOBAL</b>
22532	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	90
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	90
22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional interspace	zzz
63101	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment	90
63102	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); lumbar, single segment	90
63103	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic or lumbar, each additional level	zzz

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:** The direct practice expense details were jointly developed by surgeons from the American Association of Neurological Surgeons, the Congress of Neurological Surgeons, and the North American Spine Society. The details are based on previously submitted and (PEAC) approved data for 22532 and 63101 family codes.

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time (prior to admission):** The PEAC-approved time of 75 minutes has been applied to the four 90-day global codes. This time includes an additional 15 minutes of time for "complex spine" multidisciplinary coordination of care.

**Service period clinical staff time (admission to discharge):** Discharge management time of 12 minutes (1 X 99238) has been applied to the four 90-day global codes.

**Post-service period clinical staff time:** Standard EM postop visit time for clinical staff has been applied as appropriate for each code.

**SUPPLIES AND EQUIPMENT:**

A basic post-operative incision care kit is needed at one of the post surgical office visits. A standard multispecialty minimum visit supply package is needed for each office visit. A power table and surgical exam light is needed for each office visit.

	A	B	C	D	E	F
1				22532	22533	22534
2	22532-34 and 63101-03 Feb03 RUC	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE		Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional interspace
3		Global -->		90	90	ZZZ
4		Location -->		Facility	Facility	Facility
5	TOTAL RN/LPN/MTA CLINICAL LABOR TIME	RN/LPN/MTA		184	184	0
6	PRE-SERV CLINICAL LABOR TIME	RN/LPN/MTA		75	75	
7	SERVICE PERIOD CLINICAL LABOR TIME	RN/LPN/MTA		12	12	
8	POST-SERV CLINICAL LABOR TIME	RN/LPN/MTA		97	97	
9	<b>PRE-SERVICE</b>					
10	Complete pre-service diagnostic & referral forms	RN/LPN/MTA		5	5	
11	Coordinate pre-surgery services	RN/LPN/MTA		25	25	
12	Schedule space and equipment in facility	RN/LPN/MTA		10	10	
13	Provide pre-service education/obtain consent	RN/LPN/MTA		25	25	
14	Phone calls & prescriptions	RN/LPN/MTA		10	10	
15	Other Multispec Coordination of Care	RN/LPN/MTA		0	0	
16	<b>SERVICE PERIOD</b>					
17	Pre-service services					
18	Intra-service					
19	Post-Service					
20	Dischg day mgmt (99238 12 min) (99239 15 min)	RN/LPN/MTA		12	12	
21	Other Clinical Activity (please specify)					
22	<b>POST-SERVICE Period</b>					
23	List Number and Level of Office Visits					
24	99211 16 minutes					
25	99212 27 minutes			1	1	
26	99213 36 minutes			3	3	
27	99214 53 minutes					
28	99215 63 minutes					
29	Other					
30	Total Office Visit Time	RN/LPN/MTA		97	97	
31	Other Activity (please specify)					
32	<b>MEDICAL SUPPLIES</b>					
33	Min Supply Pack for Visits	PEAC	pk	4	4	0
34	neurosurgical post-op incision care kit		kit	1	1	0
35	<b>EQUIPMENT</b>					
36	surgical lamp	E30009		1	1	0
37	Power exam table	E11003		1	1	0

	A	B	C	G	H	I
1				63101	63102	63103
2	22532-34 and 63101-03 Feb03 RUC	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE		Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); lumbar, single segment	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic or lumbar, each additional level
3		Global -->		90	90	ZZZ
4		Location -->		Facility	Facility	Facility
5	TOTAL RN/LPN/MTA CLINICAL LABOR TIME	RN/LPN/MTA		222	222	0
6	PRE-SERV CLINICAL LABOR TIME	RN/LPN/MTA		75	75	
7	SERVICE PERIOD CLINICAL LABOR TIME	RN/LPN/MTA		12	12	
8	POST-SERV CLINICAL LABOR TIME	RN/LPN/MTA		135	135	
9	<b>PRE-SERVICE</b>					
10	Complete pre-service diagnostic & referral forms	RN/LPN/MTA		5	5	
11	Coordinate pre-surgery services	RN/LPN/MTA		25	25	
12	Schedule space and equipment in facility	RN/LPN/MTA		10	10	
13	Provide pre-service education/obtain consent	RN/LPN/MTA		25	25	
14	Phone calls & prescriptions	RN/LPN/MTA		10	10	
15	Other Multispec Coordination of Care	RN/LPN/MTA		0	0	
16	<b>SERVICE PERIOD</b>					
17	Pre-service services					
18	Intra-service					
19	Post-Service					
20	Dischg day mgmt (99238 12 min) (99239 15 min)	RN/LPN/MTA		12	12	
21	Other Clinical Activity (please specify)					
22	<b>POST-SERVICE Period</b>					
23	List Number and Level of Office Visits					
24	99211 16 minutes					
25	99212 27 minutes			1	1	
26	99213 36 minutes			3	3	
27	99214 53 minutes					
28	99215 63 minutes					
29	Other					
30	Total Office Visit Time	RN/LPN/MTA		135	135	
31	Other Activity (please specify)					
32	<b>MEDICAL SUPPLIES</b>					
33	Min Supply Pack for Visits	PEAC	pk	4	4	0
34	neurosurgical post-op incision care kit		kit	1	1	0
35	<b>EQUIPMENT</b>					
36	surgical lamp	E30009		1	1	0
37	Power exam table	E11003		1	1	0

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Transbronchial Biopsy Procedures**

The CPT Editorial Panel created a number of editorial revisions and added two new add-on codes to the family of transbronchial biopsy procedures to provide specific guidance on the reporting of biopsy(s) for single versus multiple lobes.

The RUC considered survey data from more than 30 physicians and agreed that the nomenclature changes to CPT codes 31622-31628; 31630-31631; and 31635-31640 are editorial in nature and do not change the work of the service. In reviewing these changes, the specialty argued that there is currently a rank order anomaly between the work relative value for 31629 *Bronchoscopy, {rigid or flexible}, with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)* (work rvu = 3.37) and 31625 *Bronchoscopy, {rigid or flexible}, with or without fluoroscopic guidance; with bronchial or endobronchial biopsy (s), single or multiple sites* (work rvu = 3.37). The specialty argued, and the RUC agreed, that the physician work for 31629 should be greater than 31625 as it is a more complex and riskier as the physician is placing the needle through either the trachea or bronchial wall. CPT code 31629 typically requires fluoroscopy, while 31625 rarely requires fluoroscopy. Fluoroscopic guidance is included in these services and not reported separately. The specialty informed the RUC that this code had not been surveyed in the past. The specialty presented the 25th percentile of 4.10 as the recommendation. **The RUC agreed and recommends a work relative value of 4.10 for CPT code 31629.**

CPT Codes 31632 *Bronchoscopy, rigid or flexible with or without fluoroscopic guidance; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)* and 31633 *Bronchoscopy, rigid or flexible with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)* are new CPT add-on codes. The survey respondents indicated that these services typically require 18-20 minutes of additional time for each additional lobe. The specialty was concerned that the survey respondents did not fully understand add-on codes and may have over-estimated the physician work involved in the service. The specialty, therefore, recommends that the values for these services be derived as follows:

CPT code 31632 should be valued at the increment between CPT Code 31628 *Bronchoscopy with transbronchial lung biopsy(s)* (work rvu = 3.81) and CPT Code 31622 *Bronchoscopy base code* (work rvu = 2.78), which is 1.03. **The RUC agrees and recommends a work relative value of 1.03 for CPT code 31632.**

CPT code 31633 should be valued at the increment between CPT Code 31629 *Bronchoscopy with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)* (work rvu = 4.10) and CPT Code 31622 *Bronchoscopy base code* (work rvu = 2.78), which is 1.32. **The RUC agrees and recommends a work relative value of 1.32 for CPT code 31633.**

Practice Expense Inputs

The RUC reviewed the specialty society’s presentation of practice expense inputs, which included data recently approved by the PEAC. The RUC modified the intra-service time for the existing codes to mirror the physician time from the new survey. The RUC clarified that a separate transbrochial needle is required for each biopsy and each lobe typically requires three biopsies. The recommended direct practice expense inputs are attached to the recommendations.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲ 31622		Bronchoscopy, (rigid or flexible), with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)	000	2.78 (no change)
▲ 31623		with brushing or protected brushings	000	2.88 (no change)
▲ 31624		with bronchial alveolar lavage	000	2.88 (no change)
▲ 31625	K1	with <u>bronchial or endobronchial biopsy (s), single or multiple sites</u> (31626 has been deleted. To report, use 31625) (31627 has been deleted. To report, use 31622)	000	3.37 (no change)
▲ 31628	K2	with transbronchial lung biopsy(s), single lobe, with or without fluoroscopic guidance  <u>(31628 should be reported only once regardless of how many transbronchial lung biopsies are performed in a lobe)</u>  <u>(To report transbronchial lung biopsies performed on additional lobe, use 31632)</u>	000	3.81 (no change)

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲31629	K3	<p>with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)</p> <p><u>(31629 should be reported only once for upper airway biopsies regardless of how many transbronchial needle aspiration biopsies are performed in the upper airway or in a lobe)</u></p> <p><u>(To report transbronchial needle aspiration biopsies performed in additional lobes, use 31633)</u></p>	000	4.10
▲31630		with tracheal or bronchial dilation or closed reduction of fracture	000	3.82 (no change)
▲31631		with tracheal dilation and placement of tracheal stent	000	4.37 (no change)
+●31632	K4	<p>with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)</p> <p><u>(Use 31632 in conjunction with code 31628)</u></p> <p><u>(31632 should be reported only once regardless of how many transbronchial lung biopsies are performed in a lobe)</u></p>	ZZZ	1.03
+●31633	K5	<p>with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)</p> <p><u>(Use 31633 in conjunction with code 31629)</u></p> <p><u>(31633 should be reported only once regardless of how many transbronchial needle aspiration biopsies are performed in the trachea or the additional lobe)</u></p>	ZZZ	1.32

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲31635		with removal of foreign body	000	3.68 (no change)
▲31640		with excision of tumor	000	4.94 (no change)

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

CPT Code: 31625\_ Tracking Number: K1\_ Global Period: 000\_ Recommended RVW: 3.37\_

CPT Descriptor: Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with bronchial or endobronchial biopsy(s), single or multiple sites.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A patient with bilateral hilar adenopathy is thought to have possible sarcoidosis and bronchoscopy is performed for diagnosis. Multiple bronchial mucosal biopsies are obtained by direct vision at multiple sites from the trachea and proximal lobar bronchi.

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

Description of Pre-Service Work: The patient is brought into the bronchoscopy suite and is placed in a special chair or table for bronchoscopy. The details of the procedure are reviewed with the patient, including possible complications, and the patient signs a consent form. Leads for monitoring blood pressure, pulse, ECG, and SpO<sub>2</sub> are applied to the patient, and these are monitored continuously throughout the procedure. Oxygen 2 LPM via nasal cannula is begun. The patient breathes 4% xylocaine through a hand-held nebulizer until a weight-based dosage is delivered. An IV is started and saline is run at 50cc/hour. Conscious sedation is begun after 0.6mg of atropine is given subcutaneously. Versed and Alfentanil are given intravenously until the patient is well sedated. When the patient is well sedated and aerolized xylocaine has been delivered, 2% xylocaine is delivered directly into the nostrils and mouth with an atomizer.

Description of Intra-Service Work: Once the patient has been properly sedated and locally anesthetized, the oxygen is turned up to 5 LPM. A fiberoptic bronchoscope is inserted through the nostril, visualizing the upper airways to the vocal cords. The vocal cords are visualized and observed for function. The bronchoscope is advanced into the trachea. All of the airways are inspected and the site or sites for the bronchial biopsies are determined. The biopsy forceps is advanced through the suction channel of the bronchoscope into the airways. Bronchial biopsies are obtained from one or more sites and placed in formalin. The bronchoscope is gradually withdrawn from the airways, carefully inspecting the trachea and the subglottic area, and removed from the patient. The biopsy specimens are placed in formalin and sent to Pathology.

Description of Post-Service Work: The patient's blood pressure, pulse, ECG, and SpO<sub>2</sub> are monitored. Oxygen is continued to maintain an SpO<sub>2</sub> of 92% or above. The bronchoscopy report form is filled out. The pathology slip is filled out for the biopsies. A conscious sedation form is filled out. The family is visited, and the procedure results are explained to them, as well as how the patient did during the procedure and the patient's current condition. Once the patient is awake, the bronchoscopy findings are discussed with the patient. Orders for when the patient can drink or eat are given to the patient and family. Once the patient has awakened, has stable vital signs, and feels well enough to leave, the patient is discharged from the bronchoscopy suite. Once the results from the bronchoscopy have been finalized, the patient is called, the results delivered, and plans for therapy and future studies are discussed with the patient and finalized. A letter is written to the referring physician.

**SURVEY DATA**

<b>Presenter(s):</b>	Alan Plummer, MD, FCCP & Scott Manaker, MD, PhD, FCCP
<b>Specialty(s):</b>	Pulmonary Medicine/Critical Care
<b>CPT Code:</b>	31625

Sample Size: 230	Resp n: 45	Resp %: 21%			
Sample Type: Random Augmented by Panel					
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
Survey RVW:	2.98	3.5	4.0	4.8	7.75
Pre-Service Evaluation Time:	0	5	10	20	30
Pre-Service Positioning Time:	0	5	5	10	30
Pre-Service Scrub, Dress, Wait Time:	0	5	10	16	45
Intra-Service Time:	1	20	30	30	90
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
Immed. Post-time:	<u>15</u>				
Critical Care time/visit(s):					
Other Hospital time/visit(s):					
Discharge Day Mgmt:					
Office time/visit(s):					

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

#### KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
31622	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing	000	2.78

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

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

Number of respondents who choose Key Reference Code: 34

#### TIME ESTIMATES (Median)

	<u>New/Revis. CPT Code:</u>	<u>Key Reference CPT Code:</u>
	<u>31625</u>	<u>31622</u>
Median Pre-Service Time	45	20
Median Intra-Service Time	30	25
Median Immediate Post-service Time	15	20
Median Critical Care Time		
Median Other Hospital Visit Time		
Median Discharge Day Management Time		
Median Office Visit Time		
Median Total Time	90	65

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.5	3.1
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.5	3.0
Urgency of medical decision making	3.5	3.2

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.0	3.3
--------------------------	-----	-----

Physical effort required	3.6	3.0
--------------------------	-----	-----

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.9	2.9
---	-----	-----

Outcome depends on the skill and judgement of physician	4.0	3.1
---	-----	-----

Estimated risk of malpractice suit with poor outcome	3.7	3.0
--	-----	-----

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference**  
**Service 1**  
31625                      31622

**Time Segments (Mean)**

Pre-Service intensity/complexity	2.9	2.6
----------------------------------	-----	-----

Intra-Service intensity/complexity	3.9	3.4
------------------------------------	-----	-----

Post-Service intensity/complexity	3.2	2.8
-----------------------------------	-----	-----

---

**ADDITIONAL RATIONALE**

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

A random survey was performed. To achieve consistency and ascertain the accuracy of the data, the collated survey data was reviewed by the RUC, PEAC, and CPT advisers for the two societies. Their recommendations were then reviewed and considered by members of the practice management committees of the two societies who agreed to the recommendations. The representatives from the committees were 10 in number, 3 of whom practiced in group practices in suburban settings. Additionally, there were 2 Practice Administrators and 1 RN.

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

**FREQUENCY INFORMATION**

How was this service previously reported? Using the same CPT code, 31625 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Pulmonology  Commonly  Sometimes  Rarely

Specialty Thoracic Surgery  Commonly  Sometimes  Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pulmonology Frequency 96,550

Specialty Thoracic Surgery Frequency 5,976

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

Specialty Pulmonology Frequency 28,965

Specialty Thoracic Surgery Frequency 1,793

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

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

---

CPT Code: 31628\_\_\_ Tracking Number: K2\_ Global Period: 000\_ Recommended RVW: 3.81

CPT Descriptor: Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), single lobe

---

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68-year-old woman has peripheral alveolar infiltrates in the right lower lobes that have been unchanged for six weeks. Bronchoscopy is performed and no bronchial mucosal lesions are visualized. Under fluoroscopic guidance a biopsy forceps is inserted into the area of infiltrate in the peripheral right lower lobe. Three-to-six lung biopsies are obtained, each with fluoroscopic guidance of the biopsy forceps. Specimens are submitted in a container. A postprocedure chest x-ray is obtained to evaluate for possible pneumothorax.

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

Description of Pre-Service Work: The patient is brought into the bronchoscopy suite and is placed in a special chair or table for bronchoscopy. The details of the procedure are reviewed with the patient, including possible complications, and the patient signs a consent form. Leads for monitoring blood pressure, pulse, ECG, and SpO<sub>2</sub> are applied to the patient, and these are monitored continuously throughout the procedure. Oxygen 2 LPM via nasal cannula is begun. The patient breathes 4% xylocaine through a hand-held nebulizer until a weight-based dosage is delivered. An IV is started and saline is run at 50cc/hour. Conscious sedation is begun after 0.6mg of atropine is given subcutaneously. Versed and Alfentnil are given intravenously until the patient is well sedated. When the patient is well sedated and aerolized xylocaine has been delivered, 2% xylocaine is delivered directly into the nostrils and mouth with an atomizer.

Description of Intra-Service Work: Once the patient has been properly sedated and locally anesthetized, the oxygen is turned up to 5 LPM. A fiberoptic bronchoscope is inserted through the nostril, visualizing the upper airways to the vocal cords. The vocal cords are visualized and observed for function. The bronchoscope is advanced into the trachea. All of the airways are inspected. Forceps are advanced through the suction channel of the bronchoscope into the right lower lobe bronchus leading to the infiltrate. A fluoroscope is activated and the biopsy forceps are advanced into the infiltrate, then backed off by 1-2cm. Under fluoroscopic guidance the forceps are opened, a transbronchial biopsy is obtained on expiration, the forceps are removed. Three to six biopsies are obtained in one lobe with fluoroscopic guidance. The bronchoscope is withdrawn from the airways carefully visualizing the trachea and then withdrawn from the patient. Inspection of the chest for a pneumothorax is performed with the fluoroscope. The biopsies are placed in formalin and sent to Pathology.

Description of Post-Service Work: The patient's blood pressure, pulse, ECG, SpO<sub>2</sub> are monitored. Oxygen is continued to maintain an SpO<sub>2</sub> of 92% or above. The bronchoscopy report form is filled out. The pathology slip is filled out for the biopsies. A conscious sedation form is filled out. The family is visited, and the procedure results are explained to them, as well as how the patient did during the procedure and the patient's current condition. Once the patient is awake, the bronchoscopy findings are discussed with the patient. Orders for when the patient can drink or eat are given to the patient and family. Once the patient has awakened, has stable vital signs, and feels well enough to leave, the patient is discharged from the bronchoscopy suite. Once the results from the bronchoscopy have been finalized, the patient is called, the results delivered, and plans for therapy and future studies are discussed with the patient and finalized. A letter is written to the referring physician.

---

**SURVEY DATA**

<b>Presenter(s):</b> Alan Plummer, MD, FCCP & Scott Manaker, MD, PhD, FCCP	
<b>Specialty(s):</b> Pulmonary Medicine/Critical Care	
<b>CPT Code:</b> 31628	
<b>Sample Size:</b> 230	<b>Resp n:</b> 34
<b>Resp %:</b> 15%	
<b>Sample Type:</b> Random Augmented by Panel Review	
	<b>Low      25th pctl      Median      75th pctl      High</b>
<b>Survey RVW:</b>	3      4.0      4.6      5.2      8.5
<b>Pre-Service Evaluation Time:</b>	0      5      10      20      55
<b>Pre-Service Positioning Time:</b>	0      3      10      10      30
<b>Pre-Service Scrub, Dress, Wait Time:</b>	0      5      10      15      20
<b>Intra-Service Time:</b>	1      30      40      46      180
<b>Post-Service</b>	<b>Total Min*      CPT code / # of visits</b>
<b>Immed. Post-time:</b>	<u>20</u>
<b>Critical Care time/visit(s):</b>	
<b>Other Hospital time/visit(s):</b>	
<b>Discharge Day Mgmt:</b>	
<b>Office time/visit(s):</b>	

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
31622	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing	000	2.78

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

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

**Number of respondents who choose Key Reference Code:** 32

**TIME ESTIMATES (Median)**

	<b>New/Revis. CPT Code:</b>	<b>Key Reference CPT Code:</b>
	<b>31628</b>	<b>31622</b>
Median Pre-Service Time	53	18
Median Intra-Service Time	40	42
Median Immediate Post-service Time	20	35
Median Critical Care Time		

Median Other Hospital Visit Time		
Median Discharge Day Management Time		
Median Office Visit Time		
<b>Median Total Time</b>	<b>113</b>	<b>95</b>

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.4	3.3
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.2	3.2
Urgency of medical decision making	3.8	2.9

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.5	3.0
Physical effort required	3.8	2.9

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.6	2.7
Outcome depends on the skill and judgement of physician	4.5	2.9
Estimated risk of malpractice suit with poor outcome	4.1	2.9

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference**  
31628              **Service 1**  
                         31622

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.8	2.8
Intra-Service intensity/complexity	4.5	3.1
Post-Service intensity/complexity	3.5	2.5

**ADDITIONAL RATIONALE**

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

A random survey was performed. To achieve consistency and ascertain the accuracy of the data, the collated survey data was reviewed by the RUC, PEAC, and CPT advisers for the two societies. Their recommendations were then reviewed and considered by members of the practice management committees of the two societies who agreed to the recommendations. The representatives from the committees were 10 in number, 3 of whom practiced in group practices in suburban settings. Additionally, there were 2 Practice Administrators and 1 RN.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

## FREQUENCY INFORMATION

How was this service previously reported? Using the same CPT code, 31628 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Pulmonology \_\_\_\_\_  Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely  
 Specialty Thoracic Surgery \_\_\_\_\_ Commonly  Sometimes \_\_\_\_\_ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pulmonology \_\_\_\_\_ Frequency 115,733 \_\_\_\_\_  
 Specialty Thoracic Surgery \_\_\_\_\_ Frequency 1643 \_\_\_\_\_

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

Specialty Pulmonology \_\_\_\_\_ Frequency 34,720 \_\_\_\_\_  
 Specialty Thoracic Surgery \_\_\_\_\_ Frequency 493 \_\_\_\_\_

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

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

CPT Code: 31629    Tracking Number:   K3      Global Period:   000      Recommended RVW:   4.1  

CPT Descriptor: Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 70-year-old man has a 3.5 cm subcarinal lymph node on chest CT scan. One year previously he underwent surgery for a renal cell carcinoma. Bronchoscopy is performed and a transbronchial biopsy needle (e.g., Wang Needle) is passed through the carina and aspiration biopsies are obtained from the subcarinal lymph node. Biopsy specimens are submitted in a container.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Description of Pre-Service Work: The patient is brought into the bronchoscopy suite and is placed in a special chair or table for bronchoscopy. The details of the procedure are reviewed with the patient, including possible complications, and the patient signs a consent form. Leads for monitoring blood pressure, pulse, ECG, and SpO2 are applied to the patient, and these are monitored continuously throughout the procedure. Oxygen 2 LPM via nasal cannula is begun. The patient breathes 4% xylocaine through a hand-held nebulizer until a weight-based dosage is delivered. An IV is started and saline is run at 50cc/hour. Conscious sedation is begun after 0.6mg of atropine is given subcutaneously. Versed and Alfentnil are given intravenously until the patient is well sedated. When the patient is well sedated and aerolized xylocaine has been delivered, 2% xylocaine is delivered directly into the nostrils and mouth with an atomizer.

Description of Intra-Service Work: Once the patient has been properly sedated and locally anesthetized, the oxygen is turned up to 5 LPM. A fiberoptic bronchoscope is inserted through the nostril, visualizing the upper airways to the vocal cords. The vocal cords are visualized and observed for function. The bronchoscope is advanced into the trachea. All of the airways are inspected. A transbronchial biopsy needle is passed through the bronchoscope into the trachea above the carina, where the bronchoscope has been positioned. The needle is positioned and the bronchoscope and needle are jammed through the mucosa into the subcarinal area. Manual suction is applied through a syringe to aspirate the biopsy into the needle, and the transbronchial biopsy needle is removed and the specimen is delivered into an alcohol solution. Several biopsies are obtained at the one site, and the bronchoscope is removed carefully, while inspecting the trachea and subglottic area, before removing it from the patient.

Description of Post-Service Work: The patient's blood pressure, pulse, ECG, SpO2 are monitored. Oxygen is continued to maintain an SpO2 of 92% or above. The bronchoscopy report form is filled out. The pathology slip is filled out for the biopsies. A conscious sedation form is filled out. The family is visited, and the procedure results are explained to them, as well as how the patient did during the procedure and the patient's current condition. Once the patient is awake, the bronchoscopy findings are discussed with the patient. Orders for when the patient can drink or eat are given to the patient and family. Once the patient has awakened, has stable vital signs, and feels well enough to leave, the patient is discharged from the bronchoscopy suite. Once the results from the bronchoscopy have been finalized, the patient is called, the results delivered, and plans for therapy and future studies are discussed with the patient and finalized. A letter is written to the referring physician.

**SURVEY DATA**

<b>Presenter(s):</b>	Alan Plummer, MD, FCCP & Scott Manaker, MD, PhD, FCCP
<b>Specialty(s):</b>	Pulmonary Medicine/Critical Care
<b>CPT Code:</b>	31629

<b>Sample Size:</b> 230	<b>Resp n:</b> 31	<b>Resp %:</b> 13.5%			
<b>Sample Type:</b> Random Augmented by Panel					
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	3.61	4.1	4.5	5.4	7.45
<b>Pre-Service Evaluation Time:</b>	0	5	10	20	55
<b>Pre-Service Positioning Time:</b>	0	1.75	10	10	60
<b>Pre-Service Scrub, Dress, Wait Time:</b>	0	6.25	10	13.75	20
<b>Intra-Service Time:</b>	1	22.5	30	50	75
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>20</u>				
<b>Critical Care time/visit(s):</b>					
<b>Other Hospital time/visit(s):</b>					
<b>Discharge Day Mgmt:</b>					
<b>Office time/visit(s):</b>					

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

### KEY REFERENCE SERVICE:

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
31622	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing	000	2.78

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

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

Number of respondents who choose Key Reference Code: 31622

### TIME ESTIMATES (Median)

	<u>New/Revis.</u> <u>CPT Code:</u>	<u>Key Reference</u> <u>CPT Code:</u>
	<u>31629</u>	<u>31622</u>
Median Pre-Service Time	55	18
Median Intra-Service Time	30	42
Median Immediate Post-service Time	20	35
Median Critical Care Time		
Median Other Hospital Visit Time		
Median Discharge Day Management Time		
Median Office Visit Time		
Median Total Time	105	95

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.0	2.8
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.1	2.9
Urgency of medical decision making	3.5	2.6

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.6	2.9
--------------------------	-----	-----

Physical effort required	3.8	2.6
--------------------------	-----	-----

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.3	2.6
---	-----	-----

Outcome depends on the skill and judgement of physician	4.7	2.9
---	-----	-----

Estimated risk of malpractice suit with poor outcome	3.7	2.7
--	-----	-----

**INTENSITY/COMPLEXITY MEASURES**

<b><u>CPT Code</u></b>	<b><u>Reference</u></b>
31629	<b><u>Service 1</u></b> 31622

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.7	2.7
----------------------------------	-----	-----

Intra-Service intensity/complexity	4.4	2.8
------------------------------------	-----	-----

Post-Service intensity/complexity	3.5	2.6
-----------------------------------	-----	-----

**ADDITIONAL RATIONALE**

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

A random survey was performed. To achieve consistency and ascertain the accuracy of the data, the collated survey data was reviewed by the RUC, PEAC, and CPT advisers for the two societies. Their recommendations were then reviewed and considered by members of the practice management committees of the two societies who

agreed to the recommendations. The representatives from the committees were 10 in number, 3 of whom practiced in group practices in suburban settings. Additionally, there were 2 Practice Administrators and 1 RN.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

## FREQUENCY INFORMATION

How was this service previously reported? Using the same CPT code, 31629 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Pulmonology \_\_\_\_\_ Commonly  Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_  
 Specialty Thoracic Surgery \_\_\_\_\_ Commonly  Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pulmonology \_\_\_\_\_ Frequency 17,517 \_\_\_\_\_  
 Specialty Thoracic Surgery \_\_\_\_\_ Frequency 192 \_\_\_\_\_

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

Specialty Pulmonology \_\_\_\_\_ Frequency 5,255 \_\_\_\_\_  
 Specialty Thoracic Surgery \_\_\_\_\_ Frequency 58 \_\_\_\_\_

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

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

CPT Code: 31632    Tracking Number: K4    Global Period: ZZZ\_    **Recommended RVW: 1.03**

CPT Descriptor: Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), each additional lobe

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 68-year-old woman has peripheral alveolar infiltrates in the right upper and right lower lobes that have been unchanged for six weeks. Bronchoscopy is performed and no bronchial mucosal lesions are visualized. Under fluoroscopic guidance a biopsy forceps is inserted into the area of infiltrate in the peripheral right lower lobe. Three-to-six lung biopsies are obtained, each with fluoroscopic guidance of the biopsy forceps. The procedure is then repeated in the right upper lobe using fluoroscopic guidance of the biopsy forceps into the area of peripheral infiltrate, and three-to-six lung biopsy samples are obtained from this second lesion. Specimens are submitted in separate containers for each anatomic site biopsied. A postprocedure chest x-ray is obtained to evaluate for possible pneumothorax.

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

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The bronchoscope is positioned in the right upper lobe and the biopsy forceps are introduced into the area peripheral infiltrate under the fluoroscopic guidance. 3-6 lung biopsy samples are obtained from the area. Specimens are submitted in separate containers for each anatomic site biopsied. The patient is fluoroscoped after the bronchoscope has been removed to evaluate for a pneumothorax.

Description of Post-Service Work: N/A

**SURVEY DATA**

<b>Presenter(s):</b>	Alan Plummer, MD, FCCP & Scott Manaker, MD, PhD, FCCP				
<b>Specialty(s):</b>	Pulmonary Medicine/Critical Care				
<b>CPT Code:</b>	31632				
<b>Sample Size:</b>	230	<b>Resp n:</b>	41	<b>Resp %:</b>	18%
<b>Sample Type:</b> Random Augmented by Panel					
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	.33	1.9	4.0	4.5	9.2
<b>Pre-Service Evaluation Time:</b>					
<b>Pre-Service Positioning Time:</b>					
<b>Pre-Service Scrub, Dress, Wait Time:</b>					

Intra-Service Time:	0	10	18	40	115
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
Immed. Post-time:					
Critical Care time/visit(s):					
Other Hospital time/visit(s):					
Discharge Day Mgmt:					
Office time/visit(s):					

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

---

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
31628	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), single lobe	OOO	3.81

---

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

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

Number of respondents who choose Key Reference Code: 36

**TIME ESTIMATES (Median)**

New/Revis.  
CPT Code:      Key Reference  
CPT Code:

31632      31628

Median Pre-Service Time	N/A	18
Median Intra-Service Time	18	42
Median Immediate Post-service Time	N/A	30
Median Critical Care Time	N/A	
Median Other Hospital Visit Time	N/A	5
Median Discharge Day Management Time	N/A	
Median Office Visit Time	N/A	
Median Total Time	18	95

**INTENSITY/COMPLEXITY MEASURES (Mean)**
**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.1	3.9
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.9	3.9

Urgency of medical decision making	4.1	3.9
------------------------------------	-----	-----

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.6	4.4
--------------------------	-----	-----

Physical effort required	3.9	3.9
--------------------------	-----	-----

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.3	3.8
---	-----	-----

Outcome depends on the skill and judgement of physician	4.5	4.2
---	-----	-----

Estimated risk of malpractice suit with poor outcome	3.9	3.6
--	-----	-----

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference  
Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.1	3.2
----------------------------------	-----	-----

Intra-Service intensity/complexity	4.6	4.3
------------------------------------	-----	-----

Post-Service intensity/complexity	3.2	3.1
-----------------------------------	-----	-----

--	--	--

**ADDITIONAL RATIONALE**

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

A random survey was performed. To achieve consistency and ascertain the accuracy of the data, the collated survey data was reviewed by the RUC, PEAC, and CPT advisers for the two societies. Their recommendations were then reviewed and considered by members of the practice management committees of the two societies who agreed to the recommendations. The representatives from the committees were 10 in number, 3 of whom practiced in group practices in suburban settings. Additionally, there were 2 Practice Administrators and 1 RN.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

### FREQUENCY INFORMATION

How was this service previously reported? Using code 31628 \_\_\_\_\_ (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Pulmonology \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes  Rarely

Specialty Thoracic Surgery \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes  Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pulmonology \_\_\_\_\_ Frequency 5,787 \_\_\_\_\_

Specialty Thoracic Surgery \_\_\_\_\_ Frequency 82 \_\_\_\_\_

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

Specialty Pulmonology \_\_\_\_\_ Frequency 1,736 \_\_\_\_\_

Specialty Thoracic Surgery \_\_\_\_\_ Frequency 25 \_\_\_\_\_

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

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

CPT Code: 31633 Tracking Number: K5 Global Period: ZZZ Recommended RVW: 1.32

CPT Descriptor: Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance with transbronchial needle aspiration biopsy(s), each additional lobe.

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 70-year-old man has a perihilar 2.5cm nodule in the right lower lobe and a 1.5 cm subcarinal lymph node on chest CT scan. One year previously he underwent surgery for a renal cell carcinoma. Bronchoscopy is performed and a transbronchial biopsy needle (e.g., Wang Needle) is passed through the carina and aspiration biopsies are obtained from the subcarinal lymph node. Standard biopsy forceps cannot be used to reach the perihilar nodule in the right lower lobe and under fluoroscopic guidance two transbronchial needle aspiration biopsies are obtained. Biopsy specimens are submitted separately from the two anatomic sites. A postprocedure chest x-ray is obtained to evaluate for a possible pneumothorax.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The bronchoscope is repositioned into the right lower lobe under fluoroscopic guidance. Two transbronchial needle aspiration biopsies are obtained. Biopsy specimens are submitted separately from the two anatomic sites. Fluoroscopy is performed after the bronchoscope has been removed to evaluate for a pneumothorax.

Description of Post-Service Work: N/A

**SURVEY DATA**

<b>Presenter(s):</b>	Alan Plummer, MD, FCCP & Scott Manaker, MD, PhD, FCCP				
<b>Specialty(s):</b>	Pulmonary Medicine/Critical Care				
<b>CPT Code:</b>	31633				
<b>Sample Size:</b>	230	<b>Resp n:</b>	24	<b>Resp %:</b>	10%
<b>Sample Type:</b> Random Augmented by Panel					
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	.97	2.4	3.7	4.5	9.5
<b>Pre-Service Evaluation Time:</b>					
<b>Pre-Service Positioning Time:</b>					
<b>Pre-Service Scrub, Dress, Wait Time:</b>					

Intra-Service Time:	8	15	20	35	115
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
Immed. Post-time:					
Critical Care time/visit(s):					
Other Hospital time/visit(s):					
Discharge Day Mgmt:					
Office time/visit(s):					

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

---

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
31629	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)	000	3.37

---

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

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

Number of respondents who choose Key Reference Code: 15

**TIME ESTIMATES (Median)**

	<u>New/Revis. CPT Code:</u>	<u>Key Reference CPT Code:</u>
	<u>31633</u>	<u>31629</u>
Median Pre-Service Time	N/A	18
Median Intra-Service Time	20	42
Median Immediate Post-service Time	N/A	30
Median Critical Care Time		
Median Other Hospital Visit Time		5
Median Discharge Day Management Time		
Median Office Visit Time		
<b>Median Total Time</b>	<b>20</b>	<b>95</b>

**INTENSITY/COMPLEXITY MEASURES (Mean)**
**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.9	3.8
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.1	3.8

Urgency of medical decision making	3.8	3.6
------------------------------------	-----	-----

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.7	4.3
--------------------------	-----	-----

Physical effort required	4.2	3.8
--------------------------	-----	-----

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.0	3.6
---	-----	-----

Outcome depends on the skill and judgement of physician	4.6	4.2
---	-----	-----

Estimated risk of malpractice suit with poor outcome	3.6	3.2
--	-----	-----

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference  
Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.2	3.2
----------------------------------	-----	-----

Intra-Service intensity/complexity	4.5	4.3
------------------------------------	-----	-----

Post-Service intensity/complexity	3.2	3.1
-----------------------------------	-----	-----

**ADDITIONAL RATIONALE**

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

A random survey was performed. To achieve consistency and ascertain the accuracy of the data, the collated survey data was reviewed by the RUC, PEAC, and CPT advisers for the two societies. Their recommendations were then reviewed and considered by members of the practice management committees of the two societies who agreed to the recommendations. The representatives from the committees were 10 in number, 3 of whom practiced in group practices in suburban settings. Additionally, there were 2 Practice Administrators and 1 RN.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

### FREQUENCY INFORMATION

How was this service previously reported? Using code 31629 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Pulmonology \_\_\_\_\_  Commonly  Sometimes  Rarely

Specialty Thoracic Surgery \_\_\_\_\_  Commonly  Sometimes  Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pulmonology \_\_\_\_\_ Frequency 177 \_\_\_\_\_

Specialty Thoracic Surgery \_\_\_\_\_ Frequency 2 \_\_\_\_\_

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

Specialty Pulmonology \_\_\_\_\_ Frequency 53 \_\_\_\_\_

Specialty Thoracic Surgery \_\_\_\_\_ Frequency 1 \_\_\_\_\_

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

	A	B	C	D	E	F	G	H
2			31625		31628		31629	
3	REFERENCE CODES 31622-31625.00/DA Y GLOBAL	CMS Staff Type, Medical Supply or Equipment Code	Bronchoscopy (rigid or flexible); with biopsy		Bronchoscopy with Trans Bronchial Biopsy		Bronchoscopy with Trans Bronchial Needle Aspiration (TBNA)	
4	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office
5	GLOBAL PERIOD		0	0	0	0	0	0
6	TOTAL CLINICAL LABOR TIME	1033/1140	171.0	21.0	174.0	21.0	174.0	21.0
20	TOTAL PRE-SERV CLINICAL LABOR TIME	1140	18	15	18	15	18	15
21	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	1140	150	0	153	0	153	0
22	TOTAL POST-SERV CLINICAL LABOR TIME		3	6	3	6	3	6
27	PRE-SERVICE - BEFORE ADMISSION							
28	Complete pre-service diagnostic & referral forms	RT	5	5	5	5	5	5
29	Coordinate pre-surgery services	RT	3	5	3	5	3	5
30	Schedule space and equipment in facility	RT		3		3		3
31	Provide pre-service education/obtain consent	RT	7	0	7	0	7	0
32	Follow-up phone calls & prescriptions	RT	3	2	3	2	3	2
40	SERVICE PERIOD							
42	Pre-service services							
43	Review Charts	RT	2		2		2	
44	Greet patient and provide gowning	RT	3		3		3	
45	Obtain vital signs	RT	5		5		5	
46	Prepare room, equipment, supplies	RT	2		2		2	
47	Set up Scope	RT	5		5		5	
48	Prepare and position patient/ monitor patient/ set up IV	RT	2		2		2	
49	Sedate/apply anesthesia - Conscious Sedation	1033	2		2		2	
50	Intra-service							
51	Assist physician - Conscious Sedation = Physician time	1033	30		40		30	
52	Assist physician in performing procedure	RT	20		27		20	
53	Post-Service							
54	Monitor pt following service/check tubes, monitors, drains	1033	20		25		25	
55	Clean room and equipment	RT	3		3		3	
56	Complete diagnostic forms, lab & X-ray requisitions	RT	4		4		4	
57	Clean bronchoscope	RT	30		30		30	
58	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	RT	3	6	3	6	3	6
77	MEDICAL SUPPLIES		Assumes 1 RRT and 1 RN		Assumes 1 RRT and 1 RN		Assumes 1 RRT and 1 RN	
81	Conscious Sedation Package		1		1		1	
82	eye sheilds	11124	2		2		2	
83	Multispecialty Supply Package		1		1		1	
87	denture cup	11116	1		1		1	
88	xylocaine 2% (administered via atomizer)	51505	1		1		1	
89	xylocaine 4% 20 ml	51502	1		1		1	
90	xylocaine 1% 20ml bottle	51503	1		1		1	
93	xylocaine 2% viscous jelly 5 cc	51301	1		1		1	
95	50 ml specimen cup for 1% xylocaine	14010	2		2		2	
96	gauze, 4x4	31518	20		20		20	
97	emesis basin	11506	1		1		1	
102	syringe-10ml sliptip (2)	91407	2		2		2	
103	syringe-60ml sliptip (1)	91412					2	
104	normal saline	unlisted	10cc		10cc		10cc	
105	sterile specimen traps ( 60/ea)	unlisted	1		1		1	
107	bronchial brush.(3 @ \$14 = \$42)	92019						
109	protected specimen brush (15 00)	unlisted						
116	Trans bronchial needle - cytology (58 05), see attached	unlisted					3	
123	Gastrographine- contrast	20045						
124	Scope cleaning package		1		1		1	
125	balloon dialator (3@\$250 = \$750)	93121						
126	Equipment							
127	power table	E11003	1		1		1	
128	Bronchoscope	E3123	1		1		1	
129	Biopsy Forceps (1300 )	unlisted	1		1			
130	Video System (61,000)	unlisted	1		1		1	
131	suction source with regulator	E30001	1		1		1	
132	Fluroscopy	E51070			tbd		tbd	
136								
137								
138								
139								
140								
141	Tab 12 Revised 3/20/03							

**AMA/Specialty Society Update Process  
 RUC Summary of Recommendation  
 ZZZ Global Period  
 In Office Direct Inputs**

Sample Size: 230 Response Rate: (%): 18% Global Period: ZZZ

Tracking Number: K-4 Reference Code 1 31628 Reference Code 2 \_\_\_\_\_

Geographic Practice Setting %: Rural 10% Suburban 20% Urban 70%

Type of Practice %: 7% Solo Practice  
32% Single Specialty Group  
27% Multispecialty Group  
34% Medical School Faculty Practice Plan

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

In addition to the random sample, the data were analyzed and validated by a subcommittee of the American College of Chest Physicians' Practice Management Committee and the American Thoracic Society's Clinical Practice Committee. There were nine physicians, seven of whom practice in urban areas and two of whom practice in suburban areas. Additionally, there were two practice administrators and a registered nurse.

Please describe the clinical activities of your staff:

Intra-Service Clinical Labor Activities:

A Registered Nurse assists the physician with the conscious sedation. A respiratory therapist assists the physician during the procedure(s); and completes the diagnostic forms, including labeling the additional specimen(s).

HCFA's Staff Type Code*	Clinical Labor	Service Period	Cost Estimate and Source (if applicable)
1033	RN—Conscious sedation	18 min	
Unlisted	RT—Assists physician during procedure—2/3 of physician time, allows for multitasking	12 min	
Unlisted	RT—Completes additional diagnostic forms and labels additional specimen(s)	2 min	

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
NONE				

\*From HCFA's Labor, Medical Supply, and Equipment List. If not listed provide full description, estimated cost, and cost source.

HCFA Equipment Code*	Medical Equipment	Cost Estimate and Source (if applicable)
NONE		

\*From HCFA's Labor, Medical Supply, and Equipment List. If not listed provide full description, estimated cost, and cost source.

TYPE OF SERVICE: ZZZ Global Period

SITE OF SERVICE: In-OFFICE

**Clinical Services**

**Minutes**      **Staff Type – Circle**

*Intra-service*

Assist physician in performing procedure

12\_\_\_\_\_

~~RN, LPN, MTA, Other~~  
RT\_\_\_\_\_

Other Clinical Activity (please specify)

Assist physician with conscious sedation

18

~~RN, LPN, MTA, Other~~

Complete additional diagnostic forms and label additional specimen(s)

2

RT

**AMA/Specialty Society Update Process  
 RUC Summary of Recommendation  
 ZZZ Global Period  
 In Office Direct Inputs**

Sample Size: 230 Response Rate: (%): 10% Global Period: ZZZ

Tracking Number: K-5 Reference Code 1 31629 Reference Code 2 \_\_\_\_\_

Geographic Practice Setting %: Rural 4% Suburban 21% Urban 75%

Type of Practice %: 8% Solo Practice  
21% Single Specialty Group  
33% Multispecialty Group  
38% Medical School Faculty Practice Plan

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

In addition to the random sample, the data were analyzed and validated by a subcommittee of the American College of Chest Physicians' Practice Management Committee and the American Thoracic Society's Clinical Practice Committee. There were nine physicians, seven of whom practice in urban areas and two of whom practice in suburban areas. Additionally, there were two practice administrators and a registered nurse.

Please describe the clinical activities of your staff:

Intra-Service Clinical Labor Activities:

A Registered Nurse assists the physician with the conscious sedation. A respiratory therapist assists the physician during the procedure and completes the diagnostic forms, including labeling the additional specimen(s).

HCFA's Staff Type Code*	Clinical Labor	Service Period	Cost Estimate and Source (if applicable)
1033	RN—Conscious sedation	20 min	
Unlisted	RT—Assists physician during procedure—2/3 of physician time, allowing for multitasking	13 min	
Unlisted	RT—Completes additional diagnostic forms and labels additional specimen(s)	2 min	

\*From HCFA's Labor, Medical Supply, and Equipment List If not listed provide full description, estimated cost, and cost source.

<b>HCFA's Medical Supply Code*</b>	<b>Medical Supplies</b>	<b>Quantity of Supplies</b>	<b>Units Used for Purchase</b>	<b>Cost Estimate and Source (if applicable)</b>
Unlisted	Transbronchial Needle--\$58.05 each	3	1	\$174.15

\*From HCFA's Labor, Medical Supply, and Equipment List. If not listed provide full description, estimated cost, and cost source.

<b>HCFA Equipment Code*</b>	<b>Medical Equipment</b>	<b>Cost Estimate and Source (if applicable)</b>
NONE		

\*From HCFA's Labor, Medical Supply, and Equipment List. If not listed provide full description, estimated cost, and cost source.

TYPE OF SERVICE: ZZZ Global Period

**SITE OF SERVICE: In-OFFICE**

**Clinical Services**

**Minutes**

**Staff Type – Circle**

*Intra-service*

Assist physician in performing procedure

13\_\_\_\_\_

RT\_\_\_\_\_

Other Clinical Activity (please specify)

Assist physician with conscious sedation

20

RN

Complete additional diagnostic forms and labels for additional specimen(s)

2

RT

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

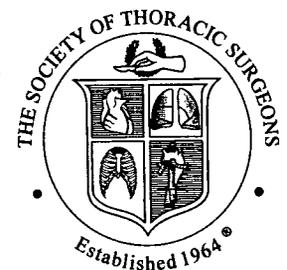
**Exploratory Cardiotomy Codes**

The CPT Editorial Panel has modified the two existing exploratory cardiotomy codes to describe the work of a patient where the removal of an atrial or ventricular thrombus is required. Currently, it is becoming more common for the intracardiac thrombus to be removed rather than removal of a foreign body, particularly with the advent of percutaneous pacing lead laser-extraction systems. By adding this terminology into the exploratory cardiotomy codes, it is clear which code should be reported for the service. These changes to the CPT descriptors, however, were deemed by the specialty society to be editorial in nature and thus do not affect the work values associated with these codes. **Therefore the RUC recommends to maintain the work relative values of CPT code 33310 *Cardiotomy, exploratory (includes removal of foreign body, atrial, or ventricular thrombus); without bypass* (RVU = 18.51) and 33315 *Cardiotomy, exploratory (includes removal of foreign body, atrial, or ventricular thrombus); with cardiopulmonary bypass* (RVU = 22.37).**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲33310	U1	Cardiotomy, exploratory (includes removal of foreign body, <u>atrial, or ventricular thrombus</u> ); without bypass	090	18.51  (no change)
▲33315	U2	with cardiopulmonary bypass  <u>(Do not report removal of thrombus (33310-33315) in addition to other cardiac procedures unless a separate incision in the heart is required to remove the atrial or ventricular thrombus.)</u>  <u>(If removal of thrombus with coronary bypass (33315) is reported in conjunction with code 33120, 33130, 33420-33430, 33460-33468, 33496, 33542, 33545, 33641-33647, 33670, 33681, 33975-33980 which requires a separate heart incision, report 33315 with modifier '-59.')</u>	090	22.37  (no change)

# THE SOCIETY OF THORACIC SURGEONS

401 N. MICHIGAN AVENUE  
CHICAGO, IL 60611  
PHONE. 312-644-6610  
FAX: 312-527-6635



March 27, 2003

James E. Hoehn, M.D.  
Chairman  
AMA/Specialty Society RVS Update Committee (RUC)  
515 North State Street  
Chicago Illinois 60610

Dear Dr. Hoehn:

The Society of Thoracic Surgeons (STS) would like to reiterate to the RUC that the proposed descriptor changes to the cardiotomy codes (33310 and 33315) are informational only and do not affect the work values associated with the codes.

The STS requested the terminology change to these codes to help clarify this coding issue for cardiothoracic surgeons. In the past atrial and/or ventricular thrombus removal have been coded using the foreign body extraction codes, or when this procedure is done in addition to another cardiac procedure, the 22 modifier has been added to the base code. The final alternative has been to use the unlisted procedure code (33999). The physician work involved in the procedure is the same because the surgeon has to make an incision into the heart to remove either a foreign body or a thrombus. It is becoming more common for intracardiac thrombus to be removed rather than removal of a foreign body, particularly with the advent of percutaneous pacing lead laser-extraction systems. By adding the terminology into the cardiotomy codes, it is clear which code should be reported for the service. While the thrombus removal will be considered incidental if the surgeon is already doing another procedure within the affected heart chamber, there are times when a separate incision into another heart chamber is required to remove the thrombus. In this case, it would be appropriate to report the thrombus removal using the multiple procedure (51) modifier. There are other situations in which thrombus removal is an isolated and independent procedure, such as when an infected thrombus is present in association with an indwelling catheter.

In order to ensure that the code is used properly, the STS provided the CPT Editorial Panel with vignettes and additional guidelines instructing surgeons when it would be appropriate to report the thrombus removal in addition to other procedures being performed in the heart.

We will be happy to answer any questions that you have regarding this issue at the upcoming RUC meeting April 22-25, 2003 in Chicago.

Sincerely,

Keith S. Naunheim, M.D.  
STS RUC Advisor

cc: John Mayer, M.D.  
Peter Smith, M.D.  
Jim Levett, M.D.

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Repair of Infrarenal Abdominal Aortic Aneurysm; Prosthesis**

Based on new information regarding FDA approval and efficacy and safety, the CPT Editorial Panel determined that the request to transition Category III code 0002T to a new code Category I code 34805, *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aortouniiliac or aortounifemoral prosthesis*, was appropriate.

A coalition of several specialties, including vascular surgery, interventional radiology, and radiology, reviewed and surveyed the new CPT code 34805. A survey median of 21.88 was collected from 44 physicians, who indicated a pre-service time of 105 minutes, an intra-service time of 150 minutes, and a post service time of 161 minutes. The RUC agreed that in comparison to the reference service code, 34800, *Endovascular repair of infra-renal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis* (RVU=20.75), the new service has 30 minutes more intra-service time. In addition, the RUC considered the intensity and complexity measures for the reference code, which were slightly higher for the new service, reasonable because both require precise attention to accurate deployment at renal artery origins. The extra intra-service time of the new service is due to the work required at the iliac drop zone. However, the RUC questioned the post-service time and determined that one 99212 and one 99213 office visit should be used instead of two 99213 visits. Therefore, the post service time was reduced by 8 minutes to a total of 153 minutes. The physician time and number of visits was also supported by building block analysis comparing the new code to the reference service code. **The RUC recommends a work relative value for CPT code 34805 of 21.88.**

**Practice Expense**

The RUC accepted the practice expense inputs after revising the post-op visits, which are based on the standard 090-day global practice expense inputs.

CPT Code (•New)	Track ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●34805	V1	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aortouniiliac or aortounifemoral prosthesis	090	21.88
0002T (D)		<del>Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; modular bifurcated prosthesis (two docking limbs); aorto-uni-iliac or aorto-unifemoral prosthesis</del>  (For radiological supervision and interpretation, use 75952 in conjunction with 0001T-0002T)		N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION

April 2003

CPT Code: 34805

Tracking No: V1

Global: 090

Recommended RVW: 21.88

**Descriptor:** Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aortouniiliac or aortounifemoral prosthesis

---

**SURVEY Vignette - Typical Patient.**

**(This is the vignette and "important note" provided for survey respondents)**

A 67-year-old male with coronary artery disease s/p MI and chronic obstructive pulmonary disease was found to have a 5.8-cm diameter abdominal aortic aneurysm (AAA) by abdominal exam and subsequent ultrasound. Risks and benefits of open surgical repair, endovascular repair, and watchful waiting are discussed with the patient, and he opts for repair. History, physical examination, and perioperative risk evaluation including cardiac workup are performed to determine the patient's suitability for surgery. Imaging studies (typically a combination of CT scan, MRI, and/or angiography) indicate that the aneurysm is infrarenal in nature with an adequate neck of normal diameter aorta below the renal artery origins to allow successful deployment of endovascular prosthesis. Distally the aneurysm extends to the very end of the aorta. One of the patient's common iliac arteries is completely occluded, and an aortouniiliac (AUI) endograft is the appropriate choice of prosthesis.

**Important Note:** As you estimate the time, intensity, and work RVUs for 34805 in the following survey, *do not include* the time, intensity or work of open femoral or iliac artery exposure, arterial catheterization, or Radiological supervision and interpretation because these services are reported separately during endovascular aortic aneurysm repair.

---

**Clinical Description of Service (this information was NOT seen by survey respondents):**

**Pre-service work:**

Pre-service work begins after the decision to operate is made, from the day before the operation until the skin incision of the operation. This activity includes obtaining and reviewing the previous work-up, with special attention to potential cardiovascular risks. In addition, an extensive and detailed review of the preoperative imaging studies (some combination of CT scan, CT angiogram, CT with 3-D reconstructions, MRI, angiograms) is required to determine the exact measurements of the aneurysm. This is necessary because an accurate preoperative choice of component diameters and lengths is one of the primary determinants of whether the endovascular procedure will be successful. In this regard endovascular repair differs substantially from open surgical AAA repair. Although imaging studies are carefully reviewed prior to open repair, the painstaking diameter and length measurements are uniquely important for the endovascular procedure. Informed consent is obtained from the patient following a discussion of surgical risks and benefits with the patient and the family. Other preservice work includes scrubbing, donning lead apparel, supervising patient positioning, waiting for the anesthetic to become effective, prepping and draping the patient. Unique to endovascular AAA repair is the preservice work of selection of equipment including guidewires, catheters, sheaths, balloons and stents.

The x-rays and measurements are re-reviewed just before the case begins to be sure the appropriate grafts are selected and available, and that appropriate extensions are available if needed.

Anesthesia for endovascular AAA repair may be general or epidural. The procedure is performed in a specially equipped suite, either an interventional radiology room suitably equipped for open surgery, or an operating room equipped with high quality fluoroscopy with angiographic capability.

**Intra-service work:**

Reporting the deployment of an AUI endovascular prosthesis will follow the detailed coding guidelines in the CPT introductory notes for Endovascular Repair of Abdominal Aortic Aneurysm. The intraservice work of 34805 typically involves:

- Perform road-mapping arteriogram with specific attention to renal artery origins
- Final examination of endovascular device for correct model, diameter, length etc
- Change to new set of sterile gloves
- Prepare Carrier and contained Endograft by flushing ports & ensuring flow valves in correct position
- Move Carrier/Endograft into place adjacent to arterial introduction site
- Anticoagulate patient with IV heparin
- Backload Carrier/Endograft on superstiff wire
- Introduce tip of Carrier/Endograft into arteriotomy
- Open proximal vascular clamp and advance front of Carrier/Endograft into artery
- Manipulate and adjust rubber constrictors to limit blood loss
- Under fluoroscopic guidance carefully direct through external iliac
- Advance Carrier/Endograft into common iliac and subsequently into aorta
- Advance Carrier/Endograft through aneurysm carefully such that tip lies above renal artery origins
- Repeat arteriography as needed to absolutely confirm renal origin location
- Begin deployment by slowly backing Carrier away from Endograft
- Make final precise adjustments to align top edge of Endograft just below renal origins
- Gently deploy remainder of Endograft with constant attention to exact positioning
- Make final position adjustments as needed
- Wiggle Carrier free of Endograft to ensure Carrier removal without malpositioning Endograft
- Remove Carrier from patient
- Balloon angioplasty proximal end of Endograft complete expansion and seating
- Use smaller balloon to complete expansion and seating of iliac end of Endograft
- (Note: All angioplasty within target zone is included in 34805, NOT separately reportable)
- Deploy stents, if needed, within body of Endograft to maintain expansion
- (Note: Stent placement in body of endograft is included in 34805, NOT separately reportable)
- Perform completion arteriogram to ensure proper position, major branch patency, r/o endoleaks
- Perform completion pressure measurement

**Post-service work:**

Post-service work begins when the patient is transferred to a post-procedure recovery unit. This includes writing orders, reviewing the hardcopy films, dictating the operative note, communicating with the patient's family, communicating with referring and consulting physicians, and participating with the anesthesiologist to ensure smooth emergence from anesthesia. Depending on the preexisting comorbidities and operative course the patient may require admission to the intensive care unit. Results of the procedure are discussed with the patient once he or she is fully awake. When stable, the patient is transferred to the floor. The physician makes daily visits to provide postoperative care. Discharge day management includes communicating with all support services such as visiting nurse, meals on wheels, etc., communicating with referring physician, providing activity advice and warnings to patient and family, and arranging office follow-up for wound checks, suture/staple removal, etc. This is a 90-day global service, so office visits within the time period are included in the RVW.

**Not included in this procedure (Separately reportable using component coding and multiple procedure payment reduction rules). This is all currently described in introductory CPT manual notes.**

- Open femoral, iliac, or brachial artery exposure as needed (CPT 34812, 34820, 34833, 34834)
- Catheter placement as needed (CPT 36200, 36245-36248)
- Fluoroscopic guidance (S&I) for carrier, endoprosthesis and catheters (CPT 75952)
- Intravascular ultrasound, if required, (CPT 37250, 37251)
- Placement of extension prosthesis, if required (CPT 34825, 34826, 75953)
- Angioplasty or stenting **outside** target zone of endoprosthesis, if required

**SURVEY DATA**

<b>Presenter(s):</b>	Gary Seabrook, M.D. Robert Zwolak, M.D. Robert Vogelzang, M.D. Bibb Allen, M.D.				
<b>Specialty(s):</b>	American Association for Vascular Surgery Society of Interventional Radiology American College of Radiology				
<b>CPT Code:</b>	34805				
<b>Sample Size:</b>	200	<b>Resp n:</b>	44	<b>Resp %:</b>	22%
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	18.00	21.00	21.88	23.00	34.00
<b>Pre-Service Evaluation Time:</b>			65		
<b>Pre-Service Positioning Time:</b>			15		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			25		
<b>Intra-Service Time:</b>	75	120	150	180	300
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	30				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	49	99232, 99231			
<b>Discharge Day Mgmt:</b>	36	99238			
<b>Office time/visit(s):</b>	46 38	99213 x 2-99212, 99213			

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

CPT	Descriptor	'03 RVW	Glob
34800	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis	20.75	090

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE:**

	Svy CPT 34805	Ref CPT 34800 RUC '04-00
<b>TIME ESTIMATES (MEDIAN)</b>		
Pre-service	105	130
Intra-service	150	120
Same Day Immediate Post-service	30	40
Critical care	0	0
Other hospital visit	49	49
Discharge day management	36	36
Office visit	4638	38
<b>TOTAL TIME</b>	<b>416 408</b>	<b>413</b>
<b>INTENSITY/COMPLEXITY MEASURES (mean)</b>		
Survey Count	21	21
<b>TIME SEGMENTS</b>		
Pre-service	4.40	4.29
Intra-service	4.40	4.33
Post-service	3.25	3.29
<b>MENTAL EFFORT AND JUDGMENT</b>		
The number of possible diagnosis and/or the number of management options that must be considered	4.40	4.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.55	4.43
Urgency of medical decision making	3.37	3.30
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>		
Technical skill required	4.60	4.43
Physical effort required	3.90	3.86
<b>PSYCHOLOGICAL STRESS</b>		
The risk of significant complications, morbidity and/or mortality	4.40	4.33
Outcome depends on the skill and judgment of physician	4.60	4.52
Estimated risk of malpractice suit with poor outcome	3.90	3.90

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

**We recommend the median survey RVW of 21.88 for this service based on the time and intensity comparisons noted above, plus multiple points of supplemental rationale provided in subsequent sections.**

Intra-service time and intensity are the major drivers of RVW for these services. Respondents indicated that the new service has **30 minutes more intra-time** than the reference service. Intensity and complexity measures are high across the board, slightly more for the new service. These two procedures are closely related on a clinical basis. Both require precise attention to accurate deployment at renal artery origins. Extra intra-time of new service is due to work required at iliac drop zone. Our recommended RVW of 21.88 is 1.13 RVUs more than the 34800 reference, and we believe that is justified by the longer intra-time plus greater intensity/complexity.

**ADDITIONAL RATIONALE**

*If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**1. IWPUT Analysis:**

The following building block analysis compares the time and visit pattern of the new code to the reference service 34800. Time and visits for these two procedures are similar. The calculated IWPUT of 0.101 turns out to be slightly less than the reference, and this differs from the subjective intensity/complexity responses. Nevertheless, as a supplemental analysis to assess the various components of a new service we believe the IWPUT, in comparison to the reference, serves only to support the recommended RVW.

ROW / COLUMN	A	B	C	D	E	F	
1	<b>34805 vs</b>	<b>34805</b>	<b>Svy RVW:</b>	<b>21.88</b>	<b>34800</b>	<b>MFS RVW:</b>	<b>20.75</b>
2	<b>34800</b>	<b>Svy Data</b>	<b>RUC Std.</b>	<b>RVW</b>	<b>Svy Data</b>	<b>RUC Std.</b>	<b>RVW</b>
3	<b>Pre-service:</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>
4	Pre: eval & posit	65	0.0224	1.46	85	0.0224	1.90
5	Pre: scrub,dress,wait	40	0.0081	0.32	45	0.0081	0.36
6	<b>Pre-service total</b>			<b>1.78</b>			<b>2.27</b>
7	<b>Post-service:</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>
8	Immediate post	30	0.0224	0.67	40	0.0224	0.90
9	<b>Subsequent visits:</b>	<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>	<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>
10	ICU 99291		4.00			4.00	
11	99233		1.51			1.51	
12	99232	1	1.06	1.06	1	1.06	1.06
13	99231	1	0.64	0.64	1	0.64	0.64
14	Discharge 99238	1	1.28	1.28	1	1.28	1.28
15	Discharge 99239		1.75			1.75	
16	99215		1.73			1.73	
17	99214		1.08			1.08	
18	99213	2	0.65	1.30	1	0.65	0.65
19	99212		0.43		1	0.43	0.43
20	99211		0.17			0.17	
21	<b>Post-service total</b>			<b>4.95</b>			<b>4.96</b>
22	<b>Intra-service:</b>	<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>	<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>
23	<b>Intra total</b>	<b>150</b>	<b>0.101</b>	<b>15.15</b>	<b>120</b>	<b>0.113</b>	<b>13.53</b>

## 2. Comparison within family of Endovascular Aneurysm repair indicates appropriate “relative” value

With the addition of 34805 there will be five endovascular aneurysm repairs in the CPT manual. Based on our recommended RVW the new code fits appropriately in this family without creating a rank order anomaly. The 5 codes are listed in order of descending RVWs:

CPT Code	Shortened Descriptor	Year Approved	RVW
34802	Endo repair aortic aneurysm using modular bifurcated prosthesis (one docking limb)	2001	23.00
34804	Endo repair aortic aneurysm using unibody bifurcated prosthesis	2001	23.00
<b>34805</b>	<b>Endo repair aortic aneurysm using aortouniliac or aortounifemoral prosthesis</b>	<b>2004 proposed</b>	<b>21.88 recommended</b>
34800	Endo repair aortic aneurysm with tube prosthesis	2001	20.75
34900	Endo repair iliac artery aneurysm	2003	16.38

The same appropriate relationship holds if one considers intra-service time, which is a primary driver of these codes:

CPT Code	Shortened Descriptor	Year Approved	Intra-service Time
34802	Endo repair aortic aneurysm using modular bifurcated prosthesis (one docking limb)	2001	150
34804	Endo repair aortic aneurysm using unibody bifurcated prosthesis	2001	150
<b>34805</b>	<b>Endo repair aortic aneurysm using aortouniliac or aortounifemoral prosthesis</b>	<b>2004 proposed</b>	<b>150</b>
34800	Endo repair aortic aneurysm with tube prosthesis	2001	120
34900	Endo repair iliac artery aneurysm	2003	120

## 3. Discussion of Pre-service Time

This new code has a pre-service time of 105 minutes. This is longer than the corresponding pre-times for some open aneurysm repair codes for good reason. Multiple diameter and length measurements must be determined beforehand to exact millimeter tolerances because if the wrong size endoprosthesis is inserted the result will be catastrophic. If the inserted device is too large it may buckle at the edges and result in an endoleak. On the other hand, if the inserted device is too small in diameter, it may slide down the aorta like an old loose sock.

Length measurements are also crucial. The bottom end of the device must land in a relatively normal segment of iliac or femoral artery where there will be a complete hemostatic seal, otherwise an endoleak will develop. In many cases the endograft must deploy above the origin of the internal iliac artery to preserve perfusion of the pelvis. In other cases the internal iliac origin is to be covered by intent, and the endoprosthesis must be long enough to reach the external iliac.

The measurements taken include aortic diameter just below renal origins, length of normal caliber aorta below renals (proximal device drop zone), maximal diameter of aneurysm, diameter of aorta at bifurcation (must be large enough to accommodate graft limbs), diameter of common iliacs, length of common iliacs, diameter and length of external iliacs, diameter of internal iliacs, and others. Multiple diagnostic modalities including CT, MRI, pre-op angiogram and others must be reviewed to make these measurements. All this work is time intensive, and 105 minutes is easily justified.

**Services Reported with Multiple CPT Codes**

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

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

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

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

**Coding Example:** The endovascular repair is the primary procedure. Balloon angioplasty and stenting within the target zone of the prosthesis are included in 34805 and are *not* separately reportable. Open femoral artery exposure (if performed) is reported separately, as is introduction of catheter in aorta. All routine radiological supervision and interpretation is reported with 75952. Payment reduction rules for multiple procedures apply (indicated by "x1/2"). RVW for 34805 is proposed survey median value.

CPT	Glob	'03 RVW	VS	RAD
34805: Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aortouniiliac prosthesis Surgeon and radiologist as co-surgeons for primary code Both report 34805-62, each is paid ½ of 1.25 x RVW	90	21.88	13.68	13.68
34812: Open femoral artery exposure for delivery of aortic endovascular prosthesis	0	6.75 x ½	3.88	
75952: Radiological S&I for endovascular AAA repair	XXX	4.50		4.50
36200: Introduce catheter in aorta	XXX	3.02 x 1/2		1.51
<b>TOTAL RVW by Specialty</b>			<b>17.56</b>	<b>19.69</b>

**Pre-Service Time**

CPT	Pre-service Time	Pre-service time with multiple service payment reduction rules A portion of this will be done by each of two physicians
34805	105	105
34812	75	0
75952	20	20
36200	0	0
Total		125 split between 2 physicians

**Intra-Service Time**

<b>CPT</b>	<b>Intra-service Time</b>	<b>Intra-service time with multiple service payment reduction rules. A portion of this will be done by each of two physicians</b>
34805	150	150
34812	45	45
75952	60	60
36200	39	39
Total		294 split between 2 physicians

**Post-Service Time**

<b>CPT</b>	<b>Post-service Time</b>	<b>Post-service time with multiple service payment reduction rules. A portion of this will be done by each of two physicians</b>
34805	161	161
34812	30	0
75952	15	15
36200	0	0
Total		176 split between two physicians

---

## FREQUENCY INFORMATION

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

0002T Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; aorto-uni-iliac or aorto-unifemoral prosthesis. This T-code has been in place since 2001, but now there is now an FDA-approved aorto-uni-iliac device. 0002T Category III code is being converted to a Category I code, and 0002T will be deleted.

**How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Vascular Surgery, Interventional Radiology, Cardiology      ~~Commonly~~      Sometimes      Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Vascular Surgery, Interventional Radiology, Cardiology  
Frequency: We do not have national frequency data for 0002T. The current means to report this procedure is CPT 0002T. 100% of the FDA-approved 0002T services will be reported with 34805. This is estimated to be less than 1,000.

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

Specialty: Vascular Surgery, Interventional Radiology, Cardiology  
Frequency: We estimate 80% of the <1,000 per year will be performed in Medicare beneficiaries. [Note: 0002T was added to the MFS 1/1/02. Medicare allowed services for 2002 claims submitted as of March 12, 2003 is 27.]

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

---

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
090 Day Global Period  
Facility Direct Inputs**

CPT	DESCRIPTION	GLOBAL
34805	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aortouniliac or aortounifemoral prosthesis	90

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:** The direct practice expense details were developed by physicians from AAVS and SIR representing a broad mix of categories of type of practice and geographic areas.

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time (prior to admission):** For each of these 90-day facility only procedures, the standard "typical" 60 minutes have been applied.

**Service period clinical staff time (admission to discharge):**

Pre-service: N/A

Intra-service: N/A

Post-service: 12 minutes of clinical staff time for work related to facility discharge.

**Post-service period clinical staff time:** Standard EM postop visit time for clinical staff has been applied for each office visit.

**SUPPLIES AND EQUIPMENT:**

Minimal supplies and equipment necessary to perform the procedures and for post op visit supplies are presented.

---

34805 PE Details (April 2003 RUC)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	34805 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, using aortouniliac or aortounifemoral prosthesis	
		90	
GLOBAL PERIOD		NonFac	Fac
LOCATION			
<b>TOTAL CLINICAL LABOR TIME</b>	<b>1130</b>	<b>N/A</b>	<b>135</b>
PRE-SERVICE PERIOD TOTAL TIME	1130		60
SERVICE PERIOD TOTAL TIME	1130		12
POST-SERVICE PERIOD TIME	1130		63
<b>PRE-SERVICE PERIOD</b>			
Complete pre-service diagnostic & referral forms	1130		5
Coordinate pre-surgery services	1130		20
Schedule space and equipment in facility	1130		8
Provide pre-service education/obtain consent	1130		20
Follow-up phone calls & prescriptions	1130		7
Other Clinical Activity (please specify)			
<b>SERVICE PERIOD</b>			
Pre-service			0
Intra-service			0
Post-Service			
Discharge day management 99238 –12 minutes 99239 –15 minutes	1130		12
Other Clinical Activity (please specify)			
<b>POST-SERVICE PERIOD</b>			
Conduct phone calls/call in prescriptions			
List Number and Level of Office Visits			
99211 16 minutes			
99212 27 minutes			1
99213 36 minutes			1
99214 53 minutes			
99215 63 minutes			
<b>Total Office Visit Time</b>	<b>1130</b>	<b>0</b>	<b>63</b>
Other Activity (please specify)			
<b>MEDICAL SUPPLIES</b>			
minimum visit package (multispecialty)	PEAC pack		2
post-op incision care kit	PEAC kit		1
<b>Equipment</b>			
exam table	E11001		1
exam lamp	E30006		1

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Upper Extremity Bypass Graft**

The CPT Editorial Panel created four new codes (35510, 35512, 35522, and 35525) to describe bypass graft of four anatomical sites of the upper extremities, and while these procedures are so rare that they have been previously coded using the unlisted procedure code, these procedures are established and new codes are warranted. The new codes involve bypass procedures that are long and complex that extend from the common carotid, subclavian, axillary or the proximal brachial arteries to the more distal brachial artery. All new codes use vein conduit.

For all four codes, the specialty society received survey data from 32 vascular surgeons.

CPT Code 35510 and 35512

The survey respondents determined a median relative value for new CPT code 35510, *Bypass graft, with vein; carotid-brachial*, to be 23.00 RVWs based on time and intensity comparisons. Respondents selected CPT code 35511, *Bypass graft, with vein; subclavian-subclavian (RVU=21.20)*, as a reference service to the procedure. Based on the results of this comparison, CPT code 35510 has 28 more minutes of pre-service time, 30 more minutes of intra-service time, and 15 more minutes of post-service time. In comparing other bypass codes, the RUC questioned the inconsistency between existing bypass codes and the new code for hospital and post-operative care visits. The specialty agreed with the RUC that the hospital visits for new code 35510 should also include one 99231 service, and the post service visits for codes 35510 are appropriate as suggested, as the incision is large. The additional hospital visit will create consistency among all of the new bypass graft codes. The accepted time for code 35510 were 103 minutes of pre-service time, 180 minutes of intra-service times, and 191 minutes post service time. Intra-service intensity, technical skill required, and risk of complications, morbidity and/or mortality are substantially higher for the new service than the reference service. Clinically, the new and reference service codes are similar, however, with dissection of the carotid artery the incremental intensity increases because of the risk of stroke. The RUC agreed that the intra-service intensity is reasonable when compared to range of intensities (0.077 – 0.100) for the family of bypass codes that are performed with vein conduit. Based on the survey results for time, and intensity comparisons, the RUC accepted the specialty society's recommendation.

**The RUC recommends a work relative value of 23.00 units for CPT code 35510.**

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

The survey respondents determined a median relative value for new CPT code 35512, *Bypass graft, with vein; subclavian-brachial*, to be 22.50 based on time and intensity comparisons. Respondents selected CPT code 35511, *Bypass graft, with vein; subclavian-subclavian (RVU=21.20)*, as a reference service to the procedure. Based on the results of this comparison, CPT code 35512 has 28 more minutes of pre-service time, 30 more minutes of intra-service time, and 32 more minutes of post-service time. The specialty agreed with the RUC that the hospital visits should also include one 99231 service, and the post service visits for code 35512 are appropriate as suggested, as the incision is large. The intensity and complexity for new code 35512 is nearly identical to the intensity of the reference service code. The most complex portion of the procedure involves dissection of the subclavian artery above the clavicle in the midst of multiple nerves and veins. In addition, the location is closer to the pleura, and pneumothorax is a potential risk. The RUC agreed with the specialty that the recommended RVU of 22.50 is justified based on the substantial extra time with essentially equal intensity.

**The RUC recommends a work relative value of 22.50 for CPT code 35512.**

#### CPT code 35522

The specialty society agreed with survey respondents that the median RVW of 21.76 appropriately reflected the time and intensity of the new service described by code 35522, *Bypass graft, with vein; axillary-brachial*, based on comparisons to the reference service code and building block analysis. The respondents selected CPT code 35518, *Bypass graft, with vein; axillary-axillary, (RVU= 21.20)*, as the reference service to this procedure. The survey respondents found that the new service has 28 minutes more pre-service time, 40 minutes more intra-service time, and 15 minutes more post-service time than the reference service. The intensity and complexity of the reference service code was nearly identical to the new code. The most complex and intense portion of the operation involves dissection of the axillary artery under the clavicle in the midst of multiple important nerves and large veins. This area is also adjacent to the pleura, and pneumothorax is an additional potential risk. Based on the extractive and the nearly equal intensity, the RUC agreed with the specialty societies recommendation of 21.76 RVWs.

**The RUC recommends a work relative value of 21.76 for CPT code 35522.**

#### CPT code 35525

The specialty society agreed with the survey respondents that the median RVW of 20.63 reflected the time and intensity of the service described by new code 35525, *Bypass graft, with vein; brachial-brachial*. Respondents selected reference service code 35518, *Bypass graft, with vein; axillary-axillary, (RVU= 21.20)*, as the reference service to the procedures. The respondents indicated that the new service has 25 minutes more pre-service time, 10 minutes more intra-service time, but 47 minutes less post-service time than the CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

reference service. The intensity and complexity values in comparison to the new code are nearly identical. The recommended RVW of 20.63 is less than the work RVU for CPT code 35518 (work RVU=21.21). With more intra-service time, and nearly identical total time and intensity, the RUC questioned how the new code was less than the reference code recommended work RVU. After discussion, the RUC understood that the possibility of nerve damage may be more likely in the case of the axillary-axillary bypass procedure, therefore a lower RVU may be justified. Therefore, the RUC agreed with the specialty society recommendation. **The RUC recommends a work relative value of 20.63 for CPT code 35525.**

The RUC clarified that venous duplex mapping is separately reported, as it is typically performed one week in advance.

Practice Expense

The RUC accepted the practice expense inputs after revising the post-operative visits, which are based on the standard 090-day global practice expense inputs.

CPT Code (•New)	Track ing Num-ber	CPT Descriptor	Global Period	Work RVU Recommendation
•35510	W1	Bypass graft, with vein; carotid-brachial	090	23.00
•35512	W2	subclavian-brachial	090	22.50
•35522	W3	axillary-brachial	090	21.76
•35525	W4	brachial-brachial	090	20.63

CPT Code: 35510

Tracking No: W1

Global: 090

Recommended RVW: 23.00

Descriptor: Bypass graft, with vein; carotid-brachial

---

**SURVEY Vignette (Typical Patient – this vignette was provided to survey respondents)**

A left-handed 70-year-old female smoker presents with disabling left upper extremity pain when she tries to perform routine activities. She also has extreme cold intolerance of the hand. Noninvasive studies confirm diminished blood pressure and flow to the hand and digits. Arteriogram reveals occlusion of the axillary artery with reconstitution of the brachial artery. Carotid-brachial bypass is performed using autogenous vein conduit.

---

**Clinical Description of Service (this information was not provided to survey respondents)**

**Pre-service work:**

Pre-service work begins after the decision to operate, from the day before the operation until the skin incision. This activity includes obtaining and reviewing the previous work-up, with special attention to potential cardiovascular risk factors. The peripheral vascular exam and the preoperative noninvasive and arteriographic studies are reviewed. Informed consent is obtained from the patient following a review of surgical risks and benefits. Discussion is held with the anesthesiologist to determine the anesthetic of choice. Duplex vein mapping studies are reviewed to ensure patient has adequate length and caliber conduit, and discussions are held with OR nurses regarding appropriate draping to expose vein donor site. Other preoperative work includes dressing, scrubbing, supervising patient positioning, waiting for the anesthetic to become effective, prepping, and draping the patient.

**Intra-service work:**

- **Proximal Dissection:** Incise skin of neck overlying common carotid artery
- Dissect soft tissue to expose carotid artery, avoid injury to multiple nearby nerves & veins
- Clear soft tissue from carotid artery for 6 cm length
- Pass soft rubber loops around artery for control
- **Distal Dissection:** Incise skin overlying brachial artery
- Dissect soft tissue from around brachial artery, avoid nerve/vein injury
- Pass soft rubber loops around artery for control
- Create a tunnel from exposed carotid artery through axilla, down arm, to brachial target site
- **Harvest Vein Conduit:** Incise skin of thigh/calf over saphenous vein
- Dissect soft tissue to identify saphenous vein
- Clear soft tissue from around saphenous vein for adequate length
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous vein and remove from lower extremity
- Test saphenous vein conduit for leaks & repair same with 7-0 vascular suture
- **Proximal Anastomosis:** Anticoagulate patient with IV heparin
- Apply vascular clamps to proximal anastomosis site on carotid artery
- Perform arteriotomy
- Perform most of vein conduit to carotid artery anastomosis with fine vascular suture
- Open clamps transiently to flush system, remove air & debris
- Complete anastomosis, remove arterial clamps
- Apply additional sutures as needed to control hemorrhage
- Pass vein conduit through tunnel to brachial artery with care to avoid twists/kinks
- **Distal Anastomosis:** Stretch vein to full length
- Perform brachial arteriotomy
- Cut vein conduit to match length and size of arteriotomy
- Perform most of vein conduit to brachial artery anastomosis with fine vascular suture
- Open clamps briefly to flush out air & debris

- Complete anastomosis
- Remove vascular clamps
- Apply additional sutures as required to achieve hemostasis
- Listen with Doppler and palpate distal pulses to assure bypass patency
- Irrigate all three incisions
- Achieve wound hemostasis
- Close all three incisions in multiple layers
- Recheck pulses to assure patency prior to application of sterile dressings

#### Post-service work

Post-service work begins after skin closure. Tasks include apply dressings, transfer patient to stretcher, accompany patient to recovery area, write orders, dictate operative note, communicate with the patient's family, communicate with referring and consulting physicians, and participate with the anesthesiologist in the recovery area to ensure smooth emergence from anesthesia. Depending on the preexisting comorbidities and operative course the patient may require admission to the intensive care unit. Results of the procedure are discussed with the patient once he or she is fully awake. The patient is transferred to the acute care ward when criteria are met. The physician makes daily visits, takes interval history, performs physical exam, makes assessment and plan, writes orders & notes, communicates with patient, family, nurses, and other care givers. Discharge day management includes communicating with all support services including visiting nurses, meals on wheels, physical therapy, etc., communicating with referring physician, providing activity advice and warnings to patient and family, and arranging office follow-up for wound checks, suture/staple removal, etc. All related post-discharge care for 90-days is included in this service.

#### SURVEY DATA

<b>Presenters:</b>	Gary Seabrook M.D., Robert Zwolak, M.D.				
<b>Specialty:</b>	American Association for Vascular Surgery				
<b>CPT Code:</b>	35510				
<b>Sample Size:</b>	200	<b>Resp n:</b>	32	<b>Resp %:</b>	16%
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	18.00	21.80	23.00	26.23	31.80
<b>Pre-Service Evaluation Time:</b>			65		
<b>Pre-Service Positioning Time:</b>			10		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			28		
<b>Intra-Service Time:</b>			180		
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	30				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	60 79	99232 x 2, 99231 x 1			
<b>Discharge Day Mgmt:</b>	36	99238			
<b>Office time/visit(s):</b>	46	99213 x 2			

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICES:**

CPT	Descriptor	'03 RVW	Glob
35511	Bypass graft, with vein, subclavian-subclavian	21.20	090

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICES:**

	Svy CPT 35510	Ref CPT 35511 RUC 2nd 5yr
<b>TIME ESTIMATES (MEDIAN)</b>		
Pre-service	103	75
Intra-service	180	150
Same Day Immediate Post-service	30	25
Critical care	0	0
Other hospital visit	60 79	60
Discharge day management	36	36
Office visit	46	36
<i>TOTAL TIME</i>	<i>474</i>	<i>384</i>
<b>INTENSITY/COMPLEXITY MEASURES (mean)</b>		
Reference Survey Response Count	8	8
<b>TIME SEGMENTS</b>		
Pre-service	3.25	3.29
Intra-service	4.25	3.86
Post-service	2.75	3.00
<b>MENTAL EFFORT AND JUDGMENT</b>		
The number of possible diagnosis and/or the number of management options that must be considered	3.38	3.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.14
Urgency of medical decision making	2.75	3.00
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>		
Technical skill required	4.25	3.57
Physical effort required	3.63	3.29
<b>PSYCHOLOGICAL STRESS</b>		
The risk of significant complications, morbidity and/or mortality	4.38	3.71
Outcome depends on the skill and judgment of physician	4.38	3.86
Estimated risk of malpractice suit with poor outcome	4.25	4.00

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

**We recommend the median survey RVW of 23.00 for this service based on the time and intensity comparisons noted above, plus the additional rationale presented in subsequent sections.**

The new service has **28 minutes more pre-time, 30 minutes more intra-time, and 15 minutes more post-time** than the reference service. Intra-service intensity, technical skill required, and risk of complications, morbidity and/or mortality are substantially higher for the new service than the reference. Both services are upper body/upper extremity bypass operations that use autogenous vein as the conduit, so they are clinically similar. Dissection of the carotid artery brings incremental intensity to the new service because risk of stroke is added to the mix. That drives the intensity of the new code. Our recommended RVW of 23.00 is 1.80 RVUs more than 35511, and we believe this is well justified based on the time and intensity comparison.



## 2. Comparison within family of bypass codes indicates appropriate "relative" value

The following table demonstrates the RVWs, intra-time, and IWPUT for a large group of bypass grafts performed with vein conduit. The procedures are sorted by RVW from low to high. The new service is bolded. We believe the recommended RVW for the new procedure is appropriately placed within this family relative to overall clinical magnitude, intra-time *and* IWPUT. We believe review of this table provides reassurance that an RVW of 23.00 will provide appropriate relative placement of the new code within the family of bypass grafts performed with vein conduit.

**RVWs in this family when intra-time = 180 minute:** Operations in this family with 180 minutes of intraservice time have RVWs ranging from 21.20 to 24.06. The current recommendation of 23.00 falls in the middle of that range.

**Family IWPUT Range:** Operations in this family involving the upper body/upper extremity have IWPUTs ranging from 0.077 to 0.100. The current proposal for 35510 has an IWPUT of 0.087, placing it at the middle of the family range.

CPT	Short Descriptor	RVW	Source	Intra-Time	IWPUT
3553X	Bypass graft with vein, brachial-brachial	20.63 proposed	Current Proposal	150	0.092
35511	Bypass graft with vein, subclavian-subclavian	21.20	Second 5-Yr review	150	0.099
35518	Bypass graft with vein, Axillary-axillary	21.20	Second 5-Yr review	140	0.094
35558	Bypass graft with vein, Femoral-femoral	21.20	Second 5-Yr review	180	0.067
35556	Bypass graft with vein, Femoral-popliteal	21.76	First 5-Yr review	200	0.048
3552X	Bypass graft with vein, Axillary-brachial	21.76 proposed	Current Proposal	180	0.077
35521	Bypass graft with vein, Axillary-femoral	22.20	Second 5-Yr review	155	0.082
3551X	Bypass graft with vein, Subclavian-brachial	22.50 proposed	Current Proposal	180	0.081
<b>35510</b>	<b>Bypass graft with vein, Carotid-brachial</b>	<b>23.00 proposed</b>	<b>Current Proposal</b>	<b>180</b>	<b>0.087</b>
35565	Bypass graft with vein, Ilio-femoral	23.20	Second 5-Yr review	180	0.078
35571	Bypass graft with vein, Popliteal-tibial	24.06	Second 5-Yr review	180	0.086
35533	Bypass graft with vein, Axillary-bifemoral	28.00	Second 5-Yr review	240	0.077
35526	Bypass graft with vein, Aorto-subclavian	29.95	Second 5-Yr review	210	0.100

**Services Reported with Multiple CPT Codes**

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

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

	The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
X	Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
X	Multiple codes allow flexibility to describe exactly what components the procedure included.
	Multiple codes are used to maintain consistency with similar codes.
	Historical precedents.
X	Other reason (please explain): In high % of cases only the primary procedure is performed and coded. Many surgeons do not perform any reportable additional maneuvers to evaluate technical adequacy of a bypass graft.

In many or most cases this procedure will not be reported with other CPT codes. The issue surrounds how a vascular surgeon evaluates the technical adequacy of a bypass graft before leaving the OR. Some surgeons simply palpate the graft pulse and distal pulses in the limb, and if present, they are satisfied. Other surgeons will listen to the bypass graft with a handheld Doppler, and that is not reportable with any additional codes. Smaller subsets will undertake completion studies using a duplex scan, a completion angiogram, or an angioscopy examination. These latter three procedures are separately reportable.

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

**Methods to assess technical adequacy of a new bypass graft in the OR, from low to hi tech:**

Method	CPT Code	Global	RVW	Intra-time
Palpate pulses	None	None	None	<5 minutes
Handheld Doppler	None	None	None	<5 minutes
Intra-op Duplex scan	93931-26	XXX	0.31	13 minutes
Completion arteriogram	75710-26	XXX	1.14	22 minutes
Angioscopy	35400	ZZZ	3.00	45 minutes

**FREQUENCY INFORMATION**

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

37799, Unlisted procedure, vascular surgery

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

Specialty: vascular surgery                      Commonly      Sometimes      Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: vascular surgery                      Frequency: less than 50

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

Specialty: vascular surgery                      Frequency: less than 50

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

---

CPT Code: 35512

Tracking No: W2 Global: 090

Recommended RVW: 22.50

**Descriptor:** Bypass graft, with vein; subclavian-brachial

---

**SURVEY Vignette (Typical Patient- this vignette given to survey respondents)**

A left-handed 70-year-old female smoker presents with disabling left upper extremity pain when she tries to perform routine activities. She also has extreme cold intolerance of the hand. Noninvasive studies confirm diminished blood pressure and flow to the hand and digits. Arteriogram reveals occlusion of the axillary and proximal brachial artery with reconstitution of the distal brachial just proximal to the elbow. Subclavian-brachial bypass is performed using autogenous vein conduit.

---

**Clinical Description of Service (this information not seen by survey respondents):**

**Pre-service work:**

Pre-service work begins after the decision to operate is made, from the day before the operation until the skin incision. This activity includes obtaining and reviewing the previous work-up, with special attention to potential cardiovascular risk factors. The peripheral vascular exam and the preoperative noninvasive and arteriographic studies are reviewed. Informed consent is obtained from the patient following a review of surgical risks and benefits. Discussion is held with the anesthesiologist to determine the anesthetic of choice. Duplex vein mapping studies are reviewed to ensure patient has adequate length and caliber conduit, and discussions are held with OR nurses regarding appropriate draping to expose vein donor site. Other preoperative work includes dressing, scrubbing, supervising patient positioning, waiting for the anesthetic to become effective, prepping, and draping the patient.

**Intra-service work:**

- **Proximal Dissection:** Incise skin above clavicle overlying subclavian artery
- Dissect soft tissue to expose subclavian artery, avoid injury to multiple nearby nerves
- Clear soft tissue from subclavian for 4 cm length
- Pass soft rubber loops around artery for control
- **Distal Dissection:** Incise skin overlying distal brachial artery just proximal to elbow
- Dissect soft tissue from around artery, avoid nerve/vein injury
- Pass soft rubber loops around artery for control
- Create a tunnel under clavicle, through axilla, down arm, to exposed brachial artery
- **Harvest Vein Conduit:** Incise skin of thigh/calf over saphenous vein
- Dissect soft tissue to identify saphenous vein
- Clear soft tissue from around saphenous vein for adequate length
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous vein and remove from lower extremity
- Test saphenous vein conduit for leaks & repair same with 7-0 vascular suture
- **Proximal Anastomosis:** Anticoagulate patient with IV heparin
- Apply vascular clamps to site of proximal anastomosis on subclavian artery
- Perform subclavian arteriotomy
- Suture vein conduit to subclavian artery with fine vascular suture
- Flush system to remove air and debris & remove clamps to test anastomosis
- Apply additional sutures as needed to control hemorrhage
- Pass vein conduit through tunnel to brachial artery with care to avoid twists/kinks
- **Distal Anastomosis:** Stretch vein to full length
- Apply vascular occluding clamps to brachial artery anastomosis site
- Perform brachial arteriotomy
- Cut vein conduit to match length and size of arteriotomy
- Perform most of the vein to brachial artery anastomosis with fine vascular suture

- Open clamps briefly to flush out air & debris
- Complete anastomosis
- Remove vascular clamps
- Apply additional sutures to anastomosis as needed to achieve hemostasis
- Listen with Doppler and palpate distal pulses to assure bypass patency
- Irrigate subclavian, brachial, and vein donor site incisions
- Close all three incisions in multiple layers
- Recheck pulses to assure patency prior to application of sterile dressings.

#### Post-service work:

Post-service work begins after skin closure. Tasks include apply dressings, transfer patient to stretcher, accompany patient to recovery area, write orders, dictate operative note, communicate with the patient's family, communicate with referring and consulting physicians, and participate with the anesthesiologist in the recovery area to ensure smooth emergence from anesthesia. Depending on the preexisting comorbidities and operative course the patient may require admission to the intensive care unit. Results of the procedure are discussed with the patient once he or she is fully awake. The patient is transferred to the acute care ward when criteria are met. The physician makes daily visits, takes interval history, performs physical exam, makes assessment and plan, writes orders & notes, communicates with patient, family, nurses, and other care givers. Discharge day management includes communicating with all support services such as visiting nurse, meals on wheels, etc., communicating with referring physician, providing activity advice and warnings to patient and family, and arranging office follow-up for wound checks, suture/staple removal, etc. All related post-discharge care for 90-days is included in this service.

#### SURVEY DATA

<b>Presenter(s):</b>	Gary Seabrook, M.D., Robert Zwolak, M.D.				
<b>Specialty:</b>	American Association for Vascular Surgery				
<b>CPT Code:</b>	35512				
<b>Sample Size:</b>	200	<b>Resp n:</b>	32	<b>Resp %:</b>	16%
<b>Sample Type:</b> Random					
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		18.00	21.62	22.50	26.92
<b>Pre-Service Evaluation Time:</b>				30	
<b>Pre-Service Positioning Time:</b>				10	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				28	
<b>Intra-Service Time:</b>		120	150	180	240
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	30				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	79	99232 x 2, 99231 x 1			
<b>Discharge Day Mgmt:</b>	36	99238			
<b>Office time/visit(s):</b>	46	99213 x 2			

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
35511	Bypass graft with vein, subclavian-subclavian	21.20	090

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

	Svy CPT 35512	Ref CPT 35511 RUC 08-00
<b>TIME ESTIMATES (MEDIAN)</b>		
Pre-service	103	75
Intra-service	<b>180</b>	<b>150</b>
Same Day Immediate Post-service	30	25
Critical care	0	0
Other hospital visit	79	60
Discharge day management	36	36
Office visit	46	38
<b>TOTAL TIME</b>	<b>474</b>	<b>384</b>

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Survey Response Count	11	11
---------------------------------	----	----

**TIME SEGMENTS**

Pre-service	3.36	3.40
Intra-service	4.09	4.10
Post-service	3.00	3.20

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	3.27	3.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.45	3.40
Urgency of medical decision making	2.80	2.80

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	4.09	3.90
Physical effort required	3.64	3.40

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	4.09	4.00
Outcome depends on the skill and judgment of physician	4.09	4.10
Estimated risk of malpractice suit with poor outcome	3.64	3.70

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

**We recommend the median survey RVW of 22.50 for this service based on the time and intensity comparisons above plus the additional rationale presented in subsequent sections.**

The new service has **28 minutes more pre-service time, 30 minutes more intra-service time, and 32 minutes more post-service time** than the reference service. The intensity and complexity values are nearly identical. The most complex and intense portion of this operation involves dissection of the subclavian artery above the clavicle in the midst of multiple nerves and veins. This is also adjacent to the pleura, and pneumothorax is additional potential risk. Our recommended RVW of 22.50 is 1.30 RVUs more than 35522, and we believe this is well justified based on the substantial extra time with essentially equal intensity.

**ADDITIONAL RATIONALE**

*If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**1. IWPUT analysis**

The following building block analysis demonstrates a similar time and visit pattern between the new service and reference procedure 35511. The calculated IWPUT of 0.081 for the new service actually turns out on the lower end of the range for this family of procedures (see next page for family table).

ROW / COLUMN	A	B	C	D	E	F
1	35512	MFS RVW:	22.50	35511	MFS RVW:	21.20
2	Svy Data	RUC Std.	RVW	Svy Data	RUC Std.	RVW
3	<b>Pre-service:</b>	Time	Intensity (=time x ints'y)	Time	Intensity (=time x ints'y)	
4	Pre: eval & posit	75	0.0224	1.68	50	0.0224
5	Pre: scrub,dress,wait	28	0.0081	0.23	25	0.0081
6	<b>Pre-service total</b>		1.91			
7	<b>Post-service:</b>	Time	Intensity (=time x ints'y)	Time	Intensity (=time x ints'y)	
8	Immediate post	30	0.0224	0.67	25	0.0224
9	<b>Subsequent visits:</b>	Visit n	E/M RVW (=n x RVW)	Visit n	E/M RVW (=n x RVW)	
10	ICU 99291		4.00			4.00
11	99233		1.51			1.51
12	99232	2	1.06	2.12	2	1.06
13	99231	1	0.64	0.64		
14	Discharge 99238	1	1.28	1.28	1	1.28
15	Discharge 99239		1.75			1.75
16	99215		1.73			1.73
17	99214		1.08			1.08
18	99213	2	0.65	1.30	1	0.65
19	99212		0.43		1	0.43
20	99211		0.17			0.17
21	<b>Post-service total</b>		6.01			5.04
22	<b>Intra-service:</b>	Time	IWPUT	INTRA-RVW	Time	IWPUT
23	<b>Intra total</b>	180	0.081	14.58	150	0.099

## 2. Comparison within family of bypass codes indicates appropriate "relative" value

The following table demonstrates the RVWs, intra-time, and IWPOT for a large group of bypass grafts performed with vein conduit. The procedures are sorted by RVW from low to high, and the new service is bolded. We believe the recommended RVW for the new procedure is appropriately placed within this family relative to overall clinical magnitude, intra-time *and* IWPOT. We believe review of this table provides reassurance that an RVW of 22.50 will provide appropriate relative placement of the new code within the family of bypass grafts performed with vein conduit.

**RVWs in this family when intra-time = 180 minute:** Operations in this family with 180 minutes of intraservice time have RVWs ranging from 21.20 to 24.06. The current recommendation of 22.50 falls in the low to middle third of that range.

**Family IWPOT Range:** Operations in this family involving the upper body/upper extremity have IWPOTs ranging from 0.077 to 0.100. The current proposal for 35512 has an IWPOT of 0.081, placing it in the lower third of the family range.

CPT	Short Descriptor	RVW	Source	Intra-Time	IWPOT
3553X	Bypass graft with vein, brachial-brachial	20.63 proposed	Current Proposal	150	0.092
35511	Bypass graft with vein, subclavian-subclavian	21.20	Second 5-Yr review	150	0.099
35518	Bypass graft with vein, Axillary-axillary	21.20	Second 5-Yr review	140	0.094
35558	Bypass graft with vein, Femoral-femoral	21.20	Second 5-Yr review	180	0.067
35556	Bypass graft with vein, Femoral-popliteal	21.76	First 5-Yr review	200	0.048
3552X	Bypass graft with vein, Axillary-brachial	21.76 proposed	Current Proposal	180	0.077
35521	Bypass graft with vein, Axillary-femoral	22.20	Second 5-Yr review	155	0.082
<b>35512</b>	<b>Bypass graft with vein, Subclavian-brachial</b>	<b>22.50 proposed</b>	<b>Current Proposal</b>	<b>180</b>	<b>0.081</b>
3550X	Bypass graft with vein, Carotid-brachial	23.00 proposed	Current Proposal	180	0.087
35565	Bypass graft with vein, Ilio-femoral	23.20	Second 5-Yr review	180	0.078
35571	Bypass graft with vein, Popliteal-tibial	24.06	Second 5-Yr review	180	0.086
35533	Bypass graft with vein, Axillary-bifemoral	28.00	Second 5-Yr review	240	0.077
35526	Bypass graft with vein, Aorto-subclavian	29.95	Second 5-Yr review	210	0.100

**Services Reported with Multiple CPT Codes**

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

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

	The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
X	Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
X	Multiple codes allow flexibility to describe exactly what components the procedure included.
	Multiple codes are used to maintain consistency with similar codes.
	Historical precedents.
X	Other reason (please explain): In high % of cases only the primary procedure is performed and coded. Many surgeons do not perform any reportable additional maneuvers to evaluate technical adequacy of a bypass graft.

In many or most cases this procedure will not be reported with other CPT codes. The issue surrounds how a vascular surgeon evaluates the technical adequacy of a bypass graft before leaving the OR. Some surgeons simply palpate the graft pulse and distal pulses in the limb, and if present, they are satisfied. Other surgeons will listen to the bypass graft with a handheld Doppler, and that is not reportable with any additional codes. Smaller subsets will undertake completion studies using a duplex scan, a completion arteriogram, or an angioscopy examination. These latter three procedures are separately reportable.

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

**Methods to assess technical adequacy of a new bypass graft in the OR, from low to hi tech:**

Method	CPT Code	Global	RVW	Intra-time
Palpate pulses	None	None	None	<5 minutes
Handheld Doppler	None	None	None	<5 minutes
Intra-op Duplex scan	93931-26	XXX	0.31	13 minutes
Completion arteriogram	75710-26	XXX	1.14	22 minutes
Angioscopy	35400	ZZZ	3.00	45 minutes

**FREQUENCY INFORMATION**

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

37799, Unlisted procedure, vascular surgery

**How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: vascular surgery                      ~~Commonly~~      Sometimes      Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: vascular surgery                      Frequency: less than 50

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

Specialty: vascular surgery                      Frequency: less than 50

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

---

CPT Code: 35522

Tracking No: W3

Global: 090

Recommended RVW: 21.76

**Descriptor:** Bypass graft, with vein; axillary-brachial

---

**SURVEY Vignette (Typical Patient - this vignette given to survey respondents)**

A left-handed 70-year-old female smoker presents with disabling left upper extremity pain when she tries to perform routine activities. She also has extreme cold intolerance of the hand. Noninvasive studies confirm diminished blood pressure and flow to the hand and digits. Arteriogram reveals occlusion of the distal axillary and proximal brachial arteries with reconstitution of the brachial artery proximal to elbow. Axillary-brachial bypass is performed using autogenous vein conduit.

---

**Clinical Description of Service (this information not seen by survey respondents):**

**Pre-service work:**

Pre-service work begins after the decision to operate, from the day before the operation until the skin incision. This activity includes obtaining and reviewing the previous work-up, with special attention to potential cardiovascular risk factors. The peripheral vascular exam and the preoperative noninvasive and arteriographic studies are reviewed. Informed consent is obtained from the patient following a review of surgical risks and benefits. Discussion is held with the anesthesiologist to determine the anesthetic of choice. Duplex vein mapping studies are reviewed to ensure patient has adequate length and caliber conduit, and discussions are held with OR nurses regarding appropriate draping to expose vein donor site. Other preoperative work includes dressing, scrubbing, supervising patient positioning, waiting for the anesthetic to become effective, prepping, and draping the patient.

**Intra-service work:**

- **Proximal Dissection:** Incise skin of chest wall just below clavicle, overlying axillary artery
- Dissect soft tissue to expose axillary artery, avoid injury to multiple nearby nerves & veins
- Clear soft tissue from axillary artery for 4 cm length
- Pass soft rubber loops around artery for control
- **Distal Dissection:** Incise skin overlying distal brachial artery just proximal to elbow
- Dissect soft tissue from around brachial artery, avoid nerve/vein injury
- Pass soft rubber loops around artery for control
- Create a tunnel from exposed axillary artery through axilla, down arm, to brachial target site
- **Harvest Vein Conduit:** Incise skin of thigh/calf over saphenous vein
- Dissect soft tissue to identify saphenous vein
- Clear soft tissue from around saphenous vein for adequate length
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous vein and remove from lower extremity
- Test saphenous vein conduit for leaks & repair same with 7-0 vascular suture
- **Proximal Anastomosis:** Anticoagulate patient with IV heparin
- Apply vascular clamps to proximal anastomosis site on axillary artery
- Perform arteriotomy
- Perform most of vein conduit to axillary artery anastomosis with fine vascular suture
- Open clamps transiently to flush system, remove air & debris
- Complete anastomosis, remove arterial clamps
- Apply additional sutures as needed to control hemorrhage
- Pass vein conduit through tunnel to brachial artery with care to avoid twists/kinks
- **Distal Anastomosis:** Stretch vein to full length
- Perform brachial arteriotomy
- Cut vein conduit to match length and size of arteriotomy
- Perform most of vein conduit to brachial artery anastomosis with fine vascular sutures
- Open clamps briefly to flush out air & debris

- Complete anastomosis
- Remove vascular clamps
- Apply additional sutures as required to achieve hemostasis
- Listen with Doppler and palpate distal pulses to assure bypass patency
- Irrigate all three incisions
- Achieve wound hemostasis
- Close all three incisions in multiple layers
- Recheck pulses to assure patency prior to application of sterile dressings

**Post-service work**

Post-service work begins after skin closure. Tasks include apply dressings, transfer patient to stretcher, accompany patient to recovery area, write orders, dictate operative note, communicate with the patient’s family, communicate with referring and consulting physicians, and participate with the anesthesiologist in the recovery area to ensure smooth emergence from anesthesia. Depending on the preexisting comorbidities and operative course the patient may require admission to the intensive care unit. Results of the procedure are discussed with the patient once he or she is fully awake. The patient is transferred to the acute care ward when criteria are met. The physician makes daily visits, takes interval history, performs physical exam, makes assessment and plan, writes orders & notes, communicates with patient, family, nurses, and other care givers. Discharge day management includes communicating with all support services including visiting nurses, meals on wheels, physical therapy, etc., communicating with referring physician, providing activity advice and warnings to patient and family, and arranging office follow-up for wound checks, suture/staple removal, etc. All related post-discharge care for 90-days is included in this service.

**SURVEY DATA**

<b>Presenters:</b>	Gary Seabrook, M.D., Robert Zwolak, M.D.					
<b>Specialty:</b>	American Association for Vascular Surgery					
<b>CPT Code:</b>	35522					
<b>Sample Size:</b>	200	<b>Resp n:</b>	32	<b>Resp %:</b>	16%	
<b>Sample Type:</b>						
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		17.00	21.00	21.76	22.00	27.00
<b>Pre-Service Evaluation Time:</b>				65		
<b>Pre-Service Positioning Time:</b>				10		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				28		
<b>Intra-Service Time:</b>				180		
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	30					
<b>Critical Care time/visit(s):</b>	0					
<b>Other Hospital time/visit(s):</b>	79	99232 x 2, 99231 x 1				
<b>Discharge Day Mgmt:</b>	36	99238				
<b>Office time/visit(s):</b>	46	99213 x 2				

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICES:**

CPT	Descriptor	'03 RVW	Glob
35518	Bypass graft with vein, axillary-axillary	21.20	090

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICES:**

	Svy CPT 35522	Ref CPT 35518 RUC 2 <sup>nd</sup> 5yr
<b>TIME ESTIMATES (MEDIAN)</b>		
Pre-service	103	75
Intra-service	180	140
Same Day Immediate Post-service	30	25
Critical care	0	0
Other hospital visit	79	109
Discharge day management	36	36
Office visit	46	38
<i>TOTAL TIME</i>	474	423

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Survey Response Count	10	10
---------------------------------	----	----

**TIME SEGMENTS**

Pre-service	3.15	3.25
Intra-service	3.62	3.58
Post-service	2.77	2.92

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	3.38	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.42
Urgency of medical decision making	2.62	2.75

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	3.85	3.75
Physical effort required	3.38	3.42

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	3.77	3.67
Outcome depends on the skill and judgment of physician	4.00	4.00
Estimated risk of malpractice suit with poor outcome	3.46	3.58

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

**We recommend the median survey RVW of 21.76 for this service based on the time and intensity comparisons above plus the additional rationale provided in subsequent sections.**

The new service has **28 minutes more pre-service time, 40 minutes more intra-service time, and 15 minutes more post-service time** than the reference service. The intensity and complexity values are nearly identical. The most complex and intense portion of this operation involves dissection of the axillary artery under the clavicle in the midst of multiple important nerves and large veins. This area is also adjacent to the pleura, and pneumothorax is an additional potential risk. Our recommended RVW of 21.76 is only 0.56 RVUs more than 35518, and we believe this is well justified based on the substantial extra time with essentially equal intensity/complexity.

**ADDITIONAL RATIONALE**

*If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**1. IWPUT analysis:**

The following building block analysis demonstrates a similar time and visit pattern between the new service and reference procedure 35518. The calculated IWPUT of 0.077 for the new service actually turns out on the lower end of the range for this family of procedures (see next page for family table).

ROW / COLUMN	A	B	C	D	E	F
1	35522	MFS RVW:	21.76	35518	MFS RVW:	21.20
2	Svy Data	RUC Std.	RVW	Svy Data	RUC Std.	RVW
3	<b>Pre-service:</b>	Time	Intensity (=time x ints'y)	Time	Intensity (=time x ints'y)	
4	Pre: eval & posit	75	0.0224	1.68	50	0.0224
5	Pre: scrub,dress,wait	28	0.0081	0.23	25	0.0081
6	<b>Pre-service total</b>		1.91			
7	<b>Post-service:</b>	Time	Intensity (=time x ints'y)	Time	Intensity (=time x ints'y)	
8	Immediate post	30	0.0224	0.67	25	0.0224
9	<b>Subsequent visits:</b>	Visit n	E/M RVW (=n x RVW)	Visit n	E/M RVW (=n x RVW)	
10	ICU 99291		4.00		4.00	
11	99233		1.51		1.51	
12	99232	2	1.06	2.12	3	1.06
13	99231	1	0.64	0.64	1	0.64
14	Discharge 99238	1	1.28	1.28	1	1.28
15	Discharge 99239		1.75		1.75	
16	99215		1.73		1.73	
17	99214		1.08		1.08	
18	99213	2	0.65	1.60	1	0.65
19	99212		0.43		1	0.43
20	99211		0.17		0.17	
21	<b>Post-service total</b>		6.01			
22	<b>Intra-service:</b>	Time	IWPUT	INTRA-RVW	Time	IWPUT
23	<b>Intra total</b>	180	0.077	13.84	140	0.094

## 2. Comparison within family of bypass codes indicates appropriate “relative” value

The following table demonstrates the RVWs, intra-time, and IWPUT for a large group of bypass grafts performed with vein conduit. The procedures are sorted by RVW from low to high, and the new service is bolded. We believe the recommended RVW for the new procedure is appropriately placed within this family relative to overall clinical magnitude, intra-time *and* IWPUT. We believe review of this table provides reassurance that an RVW of 21.76 will provide appropriate relative placement of the new code within the family of bypass grafts performed with vein conduit.

**RVWs in this family when intra-time = 180 minute:** Operations in this family with 180 minutes of intraservice time have RVWs ranging from 21.20 to 24.06. The current recommendation of 21.76 falls in the lower third of that range.

**Family IWPUT Range:** Operations in this family involving the upper body/upper extremity have IWPUTs ranging from 0.077 to 0.100. The current proposal for 35522 has an IWPUT of 0.077, placing it at the bottom of the family range.

CPT	Short Descriptor	RVW	Source	Intra-Time	IWPUT
3553X	Bypass graft with vein, brachial-brachial	20.63 proposed	Current Proposal	150	0.092
35511	Bypass graft with vein, subclavian-subclavian	21.20	Second 5-Yr review	150	0.097
35518	Bypass graft with vein, Axillary-axillary	21.20	Second 5-Yr review	140	0.094
35558	Bypass graft with vein, Femoral-femoral	21.20	Second 5-Yr review	180	0.067
35556	Bypass graft with vein, Femoral-popliteal	21.76	First 5-Yr review	200	0.048
<b>35522</b>	<b>Bypass graft with vein, Axillary-brachial</b>	<b>21.76 proposed</b>	<b>Current Proposal</b>	<b>180</b>	<b>0.077</b>
35521	Bypass graft with vein, Axillary-femoral	22.20	Second 5-Yr review	155	0.082
3551X	Bypass graft with vein, Subclavian-brachial	22.50 proposed	Current Proposal	180	0.081
3550X	Bypass graft with vein, Carotid-brachial	23.00 proposed	Current Proposal	180	0.087
35565	Bypass graft with vein, Ilio-femoral	23.20	Second 5-Yr review	180	0.078
35571	Bypass graft with vein, Popliteal-tibial	24.06	Second 5-Yr review	180	0.086
35533	Bypass graft with vein, Axillary-bifemoral	28.00	Second 5-Yr review	240	0.077
35526	Bypass graft with vein, Aorto-subclavian	29.95	Second 5-Yr review	210	0.100

**Services Reported with Multiple CPT Codes**

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

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

	The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
X	Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
X	Multiple codes allow flexibility to describe exactly what components the procedure included.
	Multiple codes are used to maintain consistency with similar codes.
	Historical precedents.
X	Other reason (please explain): In high % of cases only the primary procedure is performed and coded. Many surgeons do not perform any reportable additional maneuvers to evaluate technical adequacy of a bypass graft.

In many or most cases this procedure will not be reported with other CPT codes. The issue surrounds how a vascular surgeon evaluates the technical adequacy of a bypass graft before leaving the OR. Some surgeons simply palpate the graft pulse and distal pulses in the limb, and if present, they are satisfied. Other surgeons will listen to the bypass graft with a handheld Doppler, and that is not reportable with any additional codes. Smaller subsets will undertake completion studies using a duplex scan, a completion angiogram, or an angioscopy examination. These latter three procedures are separately reportable.

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

**Methods to assess technical adequacy of a new bypass graft in the OR, from low to hi tech:**

Method	CPT Code	Global	RVW	Intra-time
Palpate pulses	None	None	None	<5 minutes
Handheld Doppler	None	None	None	<5 minutes
Intra-op Duplex scan	93931-26	XXX	0.31	13 minutes
Completion arteriogram	75710-26	XXX	1.14	22 minutes
Angioscopy	35400	ZZZ	3.00	45 minutes

**FREQUENCY INFORMATION**

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

37799, Unlisted procedure, vascular surgery

**How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: vascular surgery                      ~~Commonly~~      ~~Sometimes~~      Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: vascular surgery                      Frequency: less than 50

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

Specialty: vascular surgery                      Frequency: less than 50

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

---

CPT Code: 35525

Tracking No: W4

Global: 090

Recommended RVW: 20.63

Descriptor: Bypass graft, with vein; brachial-brachial

---

**SURVEY Vignette (Typical Patient – this vignette given to survey respondents)**

A left-handed 70-year-old female smoker presents with disabling left upper extremity pain when she tries to perform routine activities. She also has extreme cold intolerance of the hand. Noninvasive studies confirm diminished blood pressure and flow to the hand and digits. Arteriogram reveals occlusion of the brachial artery with reconstitution of the distal brachial just beyond the elbow. Brachial-brachial bypass is performed using autogenous vein conduit.

---

**Clinical Description Of Service (this information not seen by survey respondents):**

**Pre-service work:**

Pre-service work begins after the decision to operate, from the day before the operation until the skin incision. This activity includes obtaining and reviewing the previous work-up, with special attention to potential cardiovascular risk factors. The peripheral vascular exam and the preoperative noninvasive and arteriographic studies are reviewed. Informed consent is obtained from the patient following a review of surgical risks and benefits. Discussion is held with the anesthesiologist to determine the anesthetic of choice. Duplex vein mapping studies are reviewed to ensure patient has adequate length and caliber conduit, and discussions are held with OR nurses regarding appropriate draping to expose vein donor site. Other preoperative work includes dressing, scrubbing, supervising patient positioning, waiting for the anesthetic to become effective, prepping, and draping the patient.

**Intra-service work:**

- **Proximal Dissection:** Incise skin of upper arm overlying proximal brachial artery
- Dissect soft tissue to expose brachial artery, avoid injury to multiple nearby nerves & veins
- Clear soft tissue from brachial artery for 6 cm length
- Pass soft rubber loops around artery for control
- **Distal Dissection:** Incise skin overlying distal brachial artery
- Dissect soft tissue from around brachial artery, avoid nerve/vein injury
- Pass soft rubber loops around artery for control
- Create a tunnel from proximal to distal brachial dissection sites
- **Harvest Vein Conduit:** Incise skin of thigh/calf over saphenous vein
- Dissect soft tissue to identify saphenous vein
- Clear soft tissue from around saphenous vein for adequate length
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous vein and remove from lower extremity
- Test saphenous vein conduit for leaks & repair same with 7-0 vascular suture
- **Proximal Anastomosis:** Anticoagulate patient with IV heparin
- Apply vascular clamps to proximal anastomosis site on brachial artery
- Perform arteriotomy
- Perform most of vein conduit to brachial artery anastomosis with fine vascular suture
- Open clamps transiently to flush system, remove air & debris
- Complete anastomosis, remove arterial clamps
- Apply additional sutures as needed to control hemorrhage
- Pass vein conduit through tunnel to brachial artery with care to avoid twists/kinks
- **Distal Anastomosis:** Stretch vein to full length
- Perform brachial arteriotomy
- Cut vein conduit to match length and size of arteriotomy
- Perform most of vein conduit to brachial artery anastomosis with fine vascular suture
- Open clamps briefly to flush out air & debris

- Complete anastomosis
- Remove vascular clamps
- Apply additional sutures as required to achieve hemostasis
- Listen with Doppler and palpate distal pulses to assure bypass patency
- Irrigate all three incisions
- Achieve wound hemostasis
- Close all three incisions in multiple layers
- Recheck pulses to assure patency prior to application of sterile dressings

#### Post-service work

Post-service work begins after skin closure. Tasks include apply dressings, transfer patient to stretcher, accompany patient to recovery area, write orders, dictate operative note, communicate with the patient's family, communicate with referring and consulting physicians, and participate with the anesthesiologist in the recovery area to ensure smooth emergence from anesthesia. Depending on the preexisting comorbidities and operative course the patient may require admission to the intensive care unit. Results of the procedure are discussed with the patient once he or she is fully awake. The patient is transferred to the acute care ward when criteria are met. The physician makes daily visits, takes interval history, performs physical exam, makes assessment and plan, writes orders & notes, communicates with patient, family, nurses, and other care givers. Discharge day management includes communicating with all support services including visiting nurses, meals on wheels, physical therapy, etc., communicating with referring physician, providing activity advice and warnings to patient and family, and arranging office follow-up for wound checks, suture/staple removal, etc. All related post-discharge care for 90-days is included in this service.

#### SURVEY DATA

<b>Presenters:</b>	Gary Seabrook, M.D., Robert Zwolak, M.D.				
<b>Specialty:</b>	American Association for Vascular Surgery				
<b>CPT Code:</b>	35525				
<b>Sample Size:</b>	200	<b>Resp n:</b>	32	<b>Resp %:</b>	16%
<b>Sample Type:</b>	Random				
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		14.03	19.00	20.63	21.49
<b>Pre-Service Evaluation Time:</b>				53	
<b>Pre-Service Positioning Time:</b>				10	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				28	
<b>Intra-Service Time:</b>				150	
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	30				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	49	99232 x 1, 99231 x 1			
<b>Discharge Day Mgmt:</b>	36	99238			
<b>Office time/visit(s):</b>	46	99213 x 2			

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
35518	Bypass graft with vein, axillary-axillary	21.20	090

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

<b>TIME ESTIMATES (MEDIAN)</b>	<b>Svy CPT 3552Y</b>	<b>Ref CPT 35518 RUC 2<sup>nd</sup> 5yr</b>
Pre-service	100	75
Intra-service	<b>150</b>	<b>140</b>
Same Day Immediate Post-service	30	25
Critical care	0	0
Other hospital visit	49	109
Discharge day management	36	36
Office visit	46	38
<i>TOTAL TIME</i>	<i>411</i>	<i>423</i>

**INTENSITY/COMPLEXITY MEASURES (mean)**

<b>Reference Survey Response Count</b>	9	9
--	---	---

**TIME SEGMENTS**

Pre-service	3.33	3.33
Intra-service	3.44	3.44
Post-service	2.89	2.89

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	3.33	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.56
Urgency of medical decision making	3.11	3.11

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	3.89	3.89
Physical effort required	3.56	3.56

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	3.56	3.56
Outcome depends on the skill and judgment of physician	4.00	3.89
Estimated risk of malpractice suit with poor outcome	3.56	3.56

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

**We recommend the median survey RVW of 20.63 for this service based on the time and intensity comparisons noted above, plus multiple points of supplemental rationale provided in subsequent sections.**

The new service has **25 minutes more pre-service time, 10 minutes more intra-service time, but 47 minutes less post-service time** than the reference service. The intensity and complexity values are nearly identical. Our recommended RVW of 20.63 is 0.57 RVUs less than 35518. With more intra-time, nearly identical total time, and nearly identical complexity/intensity measures, it's a little difficult to understand why this should be less than the reference.

**ADDITIONAL RATIONALE**

*If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**1. IWPUT analysis**

The following building block analysis demonstrates a similar time and visit pattern between the new service and reference procedure 35518. The calculated IWPUT of 0.092 falls within the range for this family of procedures (see next page for family table).

ROW / COLUMN	A	B	C	D	E	F
1	35525	MFS RVW:	20.63	35518	MFS RVW:	21.20
2	Svy Data	RUC Std.	RVW	Svy Data	RUC Std.	RVW
3	<b>Pre-service:</b>	<b>Time</b>	<b>Intensity (=time x ints'y)</b>	<b>Time</b>	<b>Intensity (=time x ints'y)</b>	
4	Pre: eval & posit	73	0.0224	1.64	50	0.0224
5	Pre: scrub,dress,wait	28	0.0081	0.23	25	0.0081
6	<b>Pre-service total</b>		<b>1.86</b>			
7	<b>Post-service:</b>	<b>Time</b>	<b>Intensity (=time x ints'y)</b>	<b>Time</b>	<b>Intensity (=time x ints'y)</b>	
8	Immediate post	30	0.0224	0.67	25	0.0224
9	<b>Subsequent visits:</b>	<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>	<b>Visit n</b>	<b>E/M RVW</b>
10	ICU 99291		4.00			4.00
11	99233		1.51			1.51
12	99232	1	1.06	1.06	3	1.06
13	99231	1	0.64	0.64	1	0.64
14	Discharge 99238	1	1.28	1.28	1	1.28
15	Discharge 99239		1.75			1.75
16	99215		1.73			1.73
17	99214		1.08			1.08
18	99213	2	0.65	1.30	1	0.65
19	99212		0.43		1	0.43
20	99211		0.17			0.17
21	<b>Post-service total</b>		<b>4.95</b>			<b>6.74</b>
22	<b>Intra-service:</b>	<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>	<b>Time</b>	<b>IWPUT</b>
23	<b>Intra total</b>	<b>150</b>	<b>0.092</b>	<b>13.82</b>	<b>140</b>	<b>0.094</b>

## 2. Comparison within family of bypass codes indicates appropriate “relative” value

The following table demonstrates the RVWs, intra-time, and IWPUT for a large group of bypass grafts performed with vein conduit. The procedures are sorted by RVW from low to high, and the new service is bolded. We believe the recommended RVW for the new procedure is appropriately placed within this family relative to overall clinical magnitude, intra-time *and* IWPUT. We believe review of this table provides reassurance that an RVW of 20.63 will provide appropriate relative placement of the new code within the family of bypass grafts performed with vein conduit.

**RVWs in this family:** Operations listed here have established RVWs ranging from 21.20 to 29.95. The current recommendation of 20.63 will create a new floor for that range.

**Family IWPUT Range:** Operations in this family involving the upper body/upper extremity have IWPUTs ranging from 0.077 to 0.100. The current proposal for 35525 has an IWPUT of 0.092, placing it within the family range.

CPT	Short Descriptor	RVW	Source	Intra-Time	IWPUT
<b>35525</b>	<b>Bypass graft with vein, brachial-brachial</b>	<b>20.63 proposed</b>	<b>Current Proposal</b>	<b>150</b>	<b>0.092</b>
35511	Bypass graft with vein, subclavian-subclavian	21.20	Second 5-Yr review	150	0.097
35518	Bypass graft with vein, Axillary-axillary	21.20	Second 5-Yr review	140	0.094
35558	Bypass graft with vein, Femoral-femoral	21.20	Second 5-Yr review	180	0.067
35556	Bypass graft with vein, Femoral-popliteal	21.76	First 5-Yr review	200	0.048
3552X	Bypass graft with vein, Axillary-brachial	21.76 proposed	Current Proposal	180	0.077
35521	Bypass graft with vein, Axillary-femoral	22.20	Second 5-Yr review	155	0.082
3551X	Bypass graft with vein, Subclavian-brachial	22.50 proposed	Current Proposal	180	0.081
3550X	Bypass graft with vein, Carotid-brachial	23.00 proposed	Current Proposal	180	0.087
35565	Bypass graft with vein, Ilio-femoral	23.20	Second 5-Yr review	180	0.078
35571	Bypass graft with vein, Popliteal-tibial	24.06	Second 5-Yr review	180	0.086
35533	Bypass graft with vein, Axillary-bifemoral	28.00	Second 5-Yr review	240	0.077
35526	Bypass graft with vein, Aorto-subclavian	29.95	Second 5-Yr review	210	0.100

**Services Reported with Multiple CPT Codes**

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

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

	The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
<b>X</b>	Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
<b>X</b>	Multiple codes allow flexibility to describe exactly what components the procedure included.
	Multiple codes are used to maintain consistency with similar codes.
	Historical precedents.
<b>X</b>	Other reason (please explain): In high % of cases only the primary procedure is performed and coded. Many surgeons do not perform any reportable additional maneuvers to evaluate technical adequacy of a bypass graft.

In many or most cases this procedure will not be reported with other CPT codes. The issue surrounds how a vascular surgeon evaluates the technical adequacy of a bypass graft before leaving the OR. Some surgeons simply palpate the graft pulse and distal pulses in the limb, and if present, they are satisfied. Other surgeons will listen to the bypass graft with a handheld Doppler, and that is not reportable with any additional codes. Smaller subsets will undertake completion studies using a duplex scan, a completion angiogram, or an angioscopy examination. These latter three procedures are separately reportable.

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

**Methods to assess technical adequacy of a new bypass graft in the OR, from low to hi tech:**

Method	CPT Code	Global	RVW	Intra-time
Palpate pulses	None	None	None	<5 minutes
Handheld Doppler	None	None	None	<5 minutes
Intra-op Duplex scan	93931-26	XXX	0.31	13 minutes
Completion arteriogram	75710-26	XXX	1.14	22 minutes
Angioscopy	35400	ZZZ	3.00	45 minutes

**FREQUENCY INFORMATION**

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

37799, Unlisted procedure, vascular surgery

**How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: vascular surgery                      Commonly      Sometimes      Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: vascular surgery                      Frequency: less than 50

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

Specialty: vascular surgery                      Frequency: less than 50

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

---

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
090 Day Global Period  
Facility Direct Inputs**

<b>CPT</b>	<b>DESCRIPTION</b>	<b>GLOBAL</b>
35510	Bypass graft, with vein; carotid-brachial	90
35512	Bypass graft, with vein; subclavian-brachial	90
35522	Bypass graft, with vein; axillary-brachial	90
35525	Bypass graft, with vein; brachial-brachial	90

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:** The direct practice expense details were developed by physicians from the American Association of Vascular Surgeons representing a broad mix of categories of type of practice and geographic areas.

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time (prior to admission):** For each of these 90-day facility only procedures, the standard "typical" 60 minutes have been applied.

**Service period clinical staff time (admission to discharge):**

Pre-service: N/A

Intra-service: N/A

Post-service: 12 minutes of clinical staff time for work related to facility discharge.

**Post-service period clinical staff time:** Standard EM postop visit time for clinical staff has been applied for each office visit.

**SUPPLIES AND EQUIPMENT:**

Minimal supplies and equipment necessary to perform the procedures and for post op visit supplies are presented.

---

35510-35525 PE Details (April 2003 RUC)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	35510		35512		35522		35525	
		Bypass graft, with vein, carotid-brachial		Bypass graft, with vein, subclavian-brachial		Bypass graft, with vein, axillary-brachial		Bypass graft, with vein, brachial-brachial	
		90		90		90		90	
GLOBAL PERIOD		NonFac	Fac	NonFac	Fac	NonFac	Fac	NonFac	Fac
LOCATION									
<b>TOTAL CLINICAL LABOR TIME</b>	1130	N/A	144.0	N/A	144.0	N/A	144.0	N/A	144.0
PRE-SERVICE PERIOD TOTAL TIME	1130		60.0		60.0		60.0		60.0
SERVICE PERIOD TOTAL TIME	1130		12.0		12.0		12.0		12.0
POST-SERVICE PERIOD TIME	1130		72.0		72.0		72.0		72.0
<b>PRE-SERVICE PERIOD</b>									
Complete pre-service diagnostic & referral forms	1130		5		5		5		5
Coordinate pre-surgery services	1130		20		20		20		20
Schedule space and equipment in facility	1130		8		8		8		8
Provide pre-service education/obtain consent	1130		20		20		20		20
Follow-up phone calls & prescriptions	1130		7		7		7		7
Other Clinical Activity (please specify)									
<b>SERVICE PERIOD</b>									
Pre-service			0		0		0		0
Intra-service			0		0		0		0
Post-Service									
Discharge day management 99238 --12 minutes 99239 --15 minutes	1130		12		12		12		12
Other Clinical Activity (please specify)									
<b>POST-SERVICE PERIOD</b>									
Conduct phone calls/call in prescriptions									
<i>List Number and Level of Office Visits</i>									
99211 16 minutes									
99212 27 minutes									
99213 36 minutes			2		2		2		2
99214 53 minutes									
99215 63 minutes									
<b>Total Office Visit Time</b>	1130	0	72	0	72	0	72	0	72
Other Activity (please specify)									
<b>MEDICAL SUPPLIES</b>									
minimum visit package (multispecialty)	PEAC pack		2		2		2		2
post-op incision care kit	PEAC kit		1		1		1		1
<b>Equipment</b>									
exam table	E11001		1		1		1		1
exam lamp	E30006		1		1		1		1

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Re-Implantation of Visceral Artery**

The CPT Editorial Panel created one new code, 35697 *Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery* (List separately in addition to code for primary procedure), to describe a rare number of procedures, e.g. re-implantation of the inferior mesenteric artery to prevent ischemic gangrene of the left colon during open aortic reconstruction.

A relative work value survey median of 4.25 was collected from 33 vascular surgeons, who indicated an intra-service time for the add-one code of 30 minutes. After review of the survey data, the RUC questioned the varied response from survey respondents, and also the fact that the IWPUT did not match with the recommended work RVU. In an attempt to provide stronger rationale for the recommended RVU, two competing methodologies emerged from the discussion, one based on IWPUT and the other based on selecting the 25<sup>th</sup> percentile RVU. The RUC discussed in detail these two alternatives, and determined that the appropriate RVU should be based on survey data, which takes precedence over the IWPUT. After reviewing the procedure with the specialty, the committee agreed that the 25<sup>th</sup> percentile value of 3.00 better reflected the actual work related to the procedure. As the utilization for these codes is only one percent of the total volume of six base codes (35102, 35081, 35646, 35647, 35082, 35103), **the RUC recommends that CMS determine the work neutrality based on the percentage of utilization for these six base codes.** The RUC understands that this will have minimal or no effect of these six existing codes.

**The RUC recommends a relative work value of 3.00 for CPT code 35697.**

Practice Expense

This is an add-on code and no additional practice expense inputs are necessary.

CPT Code (•New)	Track ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
+•35697	M1	Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery  (List separately in addition to code for primary procedure)  (Do not report 35697 in addition to 33877)	ZZZ	3.00

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

CPT Code: 35697

Tracking No: M1Global: ZZZ RUC Recommended RVW: 3.00 4.25

**Descriptor:** Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery  
(List separately in addition to code for primary procedure)  
(Do not report 35697 in addition to 33877)

---

**SURVEY Vignette (Typical Patient – this vignette and “Please note” were supplied to survey respondents)**

A 75-year old male undergoes open aortic aneurysm surgery (separately reported as CPT 35081 with physician work RVU=28.01). When the aneurysm is entered there is only a weak dribble of back-bleeding from the inferior mesenteric artery (IMA) origin. The surgeon completes insertion of the aortic prosthesis and restores blood flow, but the descending colon appears very dusky. The surgeon waits several minutes, but the colon does not “pink up”. A sterile hand-held Doppler is brought onto the surgical field, and no Doppler signals can be obtained at the surface of the colon. Back-bleeding from the origin of the IMA remains minimal. Gangrene of the colon will ensue if the inferior mesenteric artery is not reimplanted. IMA reimplantation is performed.

Please Note: This survey asks you to estimate only the additional physician time, intensity, and work required to reimplant the visceral artery. This is the extra or incremental work over and above that of the primary operation.

---

**Clinical Description of Service: (this information was not supplied to survey respondents)**

**Pre-service work:**

There is no preservice work. The decision to perform IMA reimplantation is almost always made during the course of the operation.

**Intra-service work:**

- Re-anticoagulate the patient with IV heparin
- Dissect soft tissue from around the origin of IMA where it exits the aorta
- Cut a 2 cm button of aortic tissue from around the origin of IMA to use as “Carrel patch”
- Examine the button to ensure that the IMA origin is smooth and patent
- Place a side-biting clamp on the aortic prosthesis at proposed site of reimplantation
- Cut hole in aortic prosthesis to match size of aorta/IMA button
- Perform anastomosis of IMA “Carrel patch” to hole in aortic prosthesis with fine vascular suture
- Flush system to remove air and debris & remove clamps to test anastomosis
- Apply additional sutures as needed to control hemorrhage
- Reverse anticoagulation with protamine, platelets, plasma, as required to achieve hemostasis

**Post-service work:**

There is no specific post-service work associated with visceral artery reimplantation.

---

**SURVEY DATA**

<b>Presenters:</b>	Gary Seabrook, M.D., and Robert Zwolak, M.D.					
<b>Specialty:</b>	American Association for Vascular Surgery					
<b>CPT Code:</b>	35697					
<b>Sample Size:</b>	200	<b>Resp n:</b>	33	<b>Resp %:</b>	%	
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		1.00	3.00	4.25	5.51	11.00
<b>Pre-Service Evaluation Time:</b>				0		
<b>Pre-Service Positioning Time:</b>				0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0		
<b>Intra-Service Time:</b>				30		
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	0					
<b>Critical Care time/visit(s):</b>	0					
<b>Other Hospital time/visit(s):</b>	0					
<b>Discharge Day Mgmt:</b>	0					
<b>Office time/visit(s):</b>	0					

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
34813	Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair	4.80	ZZZ

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

	Svy CPT 35697	Ref CPT 34813
<b>TIME ESTIMATES (MEDIAN)</b>		
Pre-service	0	0
Intra-service	30	60
Same Day Immediate Post-service	0	0
Critical care	0	0
Other hospital visit	0	0
Discharge day management	0	0
Office visit	0	0
<b>TOTAL TIME</b>	<b>30</b>	<b>60</b>

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference survey response count 7 7

**TIME SEGMENTS**

Pre-service		
Intra-service	3.14	3.00
Post-service		

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	3.14	2.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.43	2.14
Urgency of medical decision making	4.33	3.17

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	4.14	2.71
Physical effort required	2.71	2.71

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	4.29	2.86
Outcome depends on the skill and judgment of physician	4.29	3.00
Estimated risk of malpractice suit with poor outcome	4.43	3.86

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

**We recommend the median survey RVW of 4.25 for this procedure based on the time and intensity comparison to the reference code, plus the additional rationale information regarding relative rank in family of vascular surgery ZZZ codes presented on subsequent pages.**

**Note regarding budget neutrality:** The RUC is likely to question whether implementation of this new code represents an effort to create additional RVUs for an established service for work that has always been considered an inherent part of open aortic surgery. We believe the answer to that question is "no". As stated on our CPT application: "Reimplantation of the inferior mesenteric artery is performed to prevent ischemic gangrene of the left colon in approximately 1% of open aortic reconstructions. This procedure represents a very significant amount of surgical work that cannot be considered a routine part of any established aortic operation.... This is not a new procedure, but a specific code was never requested in the past because of its extreme rarity. Nevertheless, each year a small number of surgeons

request that the AAVS apply for this code since the work is real, yet not reportable by any established means.”

We realize that CMS will ultimately make a decision regarding whether the RVUs to fund this code must be carved out of the open aortic reconstructions in a budget neutral manner, and of course we will abide by their decision. Putting this issue on the table, however, will hopefully obviate unnecessary concern by the RUC. We wish to obtain a fair work valuation for the new code by the RUC, and that should really not be influenced by whatever decision CMS makes regarding budget neutrality. This is a very low volume service. We'll be happy with fair consideration and decisions, whatever they turn out to be.

**Clinical Scenario:** Reimplantation of a visceral artery during open aortic aneurysm surgery represents one of the most anxiety-producing situations one might imagine. An aortic aneurysm has just been replaced successfully with a synthetic graft, and the surgeon is about to close the abdomen. Hemostasis has been achieved by reversal of heparin anticoagulation and administration of plasma & platelets, but now the surgeon is dismayed to find the descending colon looking pretty dead. Ordinarily (approximately 99% of cases) the inferior mesenteric artery is ligated during open AAA repair because it originates from the surface of the aneurysm and because it can be sacrificed without jeopardizing colon viability.

In very rare situations, however, survival of the descending colon does depend on blood flow from the inferior mesenteric, and it must be reimplanted to prevent bowel death. The alert (albeit dismayed) surgeon re-anticoagulates the patient with IV heparin, applies proximal and distal vascular occluding clamps across the newly implanted prosthesis, cuts a hole in the new prosthesis, trims and cleans the edges of inferior mesenteric artery, then sews the artery onto the hole in the aortic graft. Clamps are removed, anastomotic bleeders are sutured, and the anticoagulation is reversed once again. The good news about all this is that patient mortality can be prevented by the procedure. It should be apparent from this short description, however, that this service carries very high urgency of decision making, technical skill, and psychological stress with respect to possibility of morbidity, mortality, etc.

**Comparison to reference code:** There were no clinically similar reference services on the survey reference service list. CPT 34813 is femoral-femoral bypass performed with a synthetic graft during elective endovascular aneurysm repair. The new service has only half the intra-time of the reference (30 vs. 60 minutes), but all intensity and complexity measures (especially urgency of decision making, technical skill, risk of bad outcome) are very much higher in the new service. The reference service has an RVW of 4.80. The new service has half the time, but much more intensity/complexity. We believe this justifies the recommended median survey value of 4.25 for the new service.



**Comparison within the closest clinical family of codes indicates appropriate "relative" value**

Thus far none of the additional rationale helps much in deciding if 4.25 is an appropriate RVW for this service. The next step we took was consideration of all vascular surgery ZZZ add-on codes. The following table includes the codes, their descriptors, the RVW and the intra-service time. They are all intra-service add-ons, so the total physician work equals the intra-work. All of the services in this table have undergone the RUC evaluation process. The new code with proposed value is bolded. The services are arranged sorted by RVW, from lowest to highest.

**We reviewed this entire table in detail, and we believe that the best reference service probably turns out to be 34826 placement of a proximal or distal extension cuff during endovascular aortic aneurysm repair (unfortunately this was not on the survey reference service list). The new service and 34826 both have intra-times of 30 minutes. Both services involve extremely high intensity aspects of treating aortic aneurysms. 34826 has an RVW of 4.13. We believe this is the best justification for an RVW of 4.25 for the new service.**

CPT Code	2003 Descriptor	2003 Work RVU	Intra-service time
35400	Angioscopy during therapeutic intervention (List separately in addition to code for primary procedure)	3.00	45
35700	Reoperation, femoral-popliteal or femoral-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	300**
35390	Reoperation add-on for re-do carotid endarterectomy (List separately in addition to code for primary procedure.)	3.19	180**
35686	Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis)	3.35	35
35685	Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit	4.05	45
34808	Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure.)	4.13	60
34826	Placement of proximal or distal extension prosthesis during endovascular AAA repair; each additional vessel (List separately in addition to code for primary procedure.)	4.13	30
<b>35697</b>	<b>Reimplantation, visceral artery to infrarenal aortic prosthesis, ea. artery</b>	<b>4.25</b>	<b>30</b>
34813	Placement of femoral-femoral prosthetic graft during endovascular AAA repair (List separately in addition to code for primary procedure.)	4.80	60
35500	Harvest upper extremity vein, one segment, for lower extremity bypass (List separately in addition to code for primary procedure)	6.45	60
35572	Harvest of femoropopliteal vein, one segment, for vascular reconstruction procedure (eg, aortic, vena Cava, coronary, peripheral artery)	6.82	60
35682	Bypass graft, autogenous composite, two segments of vein from two locations (list separately in addition to code for primary procedure)	7.20	78
35683	Bypass graft; composite, three or more segments of vein from two or more locations (List separately in addition to code for primary procedure.)	8.50	90

**\*\* These time values are from RUC database. We suspect they represent time of original service, not the time exclusively related to the add-on. Todd may wish to check this out.**

**Services Reported with Multiple CPT Codes**

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

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

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

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

CPT Code	Descriptor	Global	RVW	Intra-time
35081	Open AAA repair, tube	090	28.01	203
35697	Reimplant visceral artery	ZZZ	4.25	30

**FREQUENCY INFORMATION**

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

37799, Unlisted procedure, vascular surgery

**How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: vascular surgery                      ~~Commonly~~      Sometimes      Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: vascular surgery, general surgery                      Frequency: 300-500

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

Specialty: vascular surgery, general surgery                      Frequency: 300-500

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

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
ZZZ Global Period  
Facility Direct Inputs**

<b>CPT</b>	<b>DESCRIPTION</b>	<b>GLOBAL</b>
35697	Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery	ZZZ

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:** The direct practice expense details were developed by physicians from the American Association of Vascular Surgeons representing a broad mix of categories of type of practice and geographic areas.

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time (prior to admission):** N/A

**Service period clinical staff time (admission to discharge):** N/A

**Post-service period clinical staff time:** N/A

**SUPPLIES AND EQUIPMENT:** N/A

---

35697 PE Details (April 2003 RUC)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	35697 Reimplantation, visceral artery to infrarenal aortic, prosthesis, each artery	
		ZZZ	
GLOBAL PERIOD		NonFac	Fac
LOCATION			
TOTAL CLINICAL LABOR TIME	1130	0	0
PRE-SERVICE PERIOD TOTAL TIME	1130		
SERVICE PERIOD TOTAL TIME	1130		
POST-SERVICE PERIOD TIME	1130		
<b>PRE-SERVICE PERIOD</b>			
Complete pre-service diagnostic & referral forms	1130		
Coordinate pre-surgery services	1130		
Schedule space and equipment in facility	1130		
Provide pre-service education/obtain consent	1130		
Follow-up phone calls & prescriptions	1130		
Other Clinical Activity (please specify)			
<b>SERVICE PERIOD</b>			
Pre-service			
Intra-service			
Post-Service			
Discharge day management 99238 --12 minutes 99239 --15 minutes	1130		
Other Clinical Activity (please specify)			
<b>POST-SERVICE PERIOD</b>			
Conduct phone calls/call in prescriptions			
List Number and Level of Office Visits			
99211 16 minutes			
99212 27 minutes			
99213 36 minutes			
99214 53 minutes			
99215 63 minutes			
Total Office Visit Time	1130		
Other Activity (please specify)			
<b>MEDICAL SUPPLIES</b>			
minimum visit package (multispecialty)	PEAC pack		
post-op incision care kit	PEAC kit		
<b>Equipment</b>			
exam table	E11001		
exam lamp	E30006		

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Central Venous Access Procedures**

History

In the second, Five-Year Review of the RBRVS, CPT code 36489 *Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous over age 2* was increased from 1.22 to 2.50 work relative value units, as a rank order anomaly existed between this service and CPT code 36010 *Introduction of catheter, superior or inferior vena cava* (work RVU = 2.43). In addition, a number of other services in the family were identified as potentially mis-valued. CPT codes 36533, 36534, and 36535, which described the insertion, revision, and removal of implantable venous access device, and/or subcutaneous reservoir were considered by the RUC, but the RUC noted that the descriptor stated “and/or subcutaneous reservoir.” The RUC stated that there are multiple venous access capabilities for varying disease processes which require varying degrees of work for different venous access devices. Therefore, the RUC agreed to refer this issue to CPT to create specific codes that are more descriptive of the actual service being performed.

The CPT Editorial Panel created a Central Venous Access Procedures Workgroup, who worked on this issue for nearly two years. The results of their efforts is a new section in CPT for Central Venous Access Procedures that describes these services in five categories:

1. Insertion (placement of catheter through a newly established venous access)
2. Repair (fixing device without replacement of either catheter or port/pump, other than pharmacologic or mechanical correction of intracatheter or pericatheter occlusion (see 36535 or 36536 for those procedures)
3. Partial replacement of only the catheter component associated with a port/pump device, but not entire device.
4. Complete replacement of entire device via same venous access site (complete exchange).
5. Removal of entire device.

Work Relative Value Recommendations

Five specialties participated in a survey of the physician work involved in this family of services, including general surgery, radiology, interventional radiology, pediatric surgery, and anesthesiology. The specialties then met to review the survey results and develop consensus recommendations. At the April RUC meeting, these specialties met with a pre-facilitation committee on several occasions to further refine their recommendations to the RUC. The specialties did note that the surveys were problematic. For example, there was not a difference in work indicated for pediatric patients. The specialty believes this is due to few pediatric surgeons participating CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

in the survey. The RUC agreed that a difference should be reflected in the final RUC recommendations. The RUC reviewed alternative ways to value codes, such as the use of IWPUT, and steps to ensure appropriate rank order and relativity within the family of services.

In developing the recommendations, the specialties arranged the CPT codes into families of similar services, based upon the original code which was replaced. An anchor code was selected based upon frequency, or the base code, or upon a direct cross-walk. The specialties reviewed the IWPUT of the survey results and used this IWPUT as a general guide to each family of codes. The IWPUT was used as a check of the value determined by the survey and of the relationships within a family and between types of codes (eg, pediatric versus adult codes).

The RUC agreed with the specialties' presentation, as the pre-facilitation committee had significant input into the final work relative value recommendations. A rationale for the work relative value for each individual CPT code is attached. The following attachments are appended to this recommendation:

- Attachment A: Survey sample and response distribution for each of the procedure codes
- Attachment B: Comparison data for reference and surveyed procedure codes
- Attachment C: Rationale for work relative value recommendations for individual CPT codes
- Attachment D: Medicare utilization and new frequency estimated percentages. The RUC reviewed this document and understands that the relative value recommendations for this new family of services are work neutral to the old family of services.

### Practice Expense Inputs

The RUC reviewed the practice expense inputs and had numerous questions regarding the pre-service time. The specialties then prepared the attached spreadsheet labeled "pre-time rationale.xls" that identifies for each code the following: whether or not the service requires conscious sedation; whether it is performed on the same date as an E/M service; and a description of the typical patient scenario. The specialty also provided the specific break down of pre-service clinical staff time. The RUC reviewed this allocation of time and understands that it is consistent with the gastrointestinal endoscopic and colon and rectal surgery services that have been refined through the PEAC. The PEAC/RUC have granted time closer to 30 minutes pre-time for services that involve stents, etc. The CVA codes that are assigned 26 minutes pre-time for the facility setting involve services that require lines, ports, and pumps.

The RUC also revised staff, supplies, and equipment for the radiology add-on codes, 75998 (L27) and 76937 (L28). These codes, however, will be included in the zero work pool. A letter is attached that explains that CPT code 76003 should be utilized as a CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

crosswalk for code 75998 (L27) and CPT code 76942 should be utilized as a cross-walk for code 76937 (L28). However, it should be noted that the clinical staff time for new code 76937 is only 25% of the staff time required for code 76942. The RUC recommends that CMS adjust the cross-walked practice expense relative value accordingly.

The revised practice expense recommendations and supporting materials are attached to the recommendations.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
36488		Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, age 2 years or under	000	N/A
36489		percutaneous, over age 2 (If imaging guidance is performed, see 76000, 76003, 76942)	000	N/A
36490		age 2 years or under	000	N/A
36491		cutdown, over age 2  (For examination of patient and instruction to patient, review of prescription of fluids for long term or permanent hyperalimentation, use Evaluation and Management codes for office or hospital inpatient category or follow up inpatient consultation codes as appropriate)  (36488-36491 have been deleted. To report, see 36555-36556, 36556, 36568-36569, 36580, 36584))	000	N/A
36493		Repositioning of previously placed central venous catheter under fluoroscopic guidance  (For fluoroscopic guidance use 76000)  (36493 has been deleted. To report, use 36597)	000	N/A
(36495-36497 have been deleted. To report, see 36560-36561, 36565-36566, 36570-36571, 36589-36590, 36576-36578, 36582-36583, 36585)				

36530		<p><del>Insertion of implantable intravenous infusion pump</del>  <del>(If imaging guidance is performed, see 76000, 76003, 76942)</del></p> <p><del>(36530 has been deleted. To report, use 36563)</del></p>	010	N/A
36531		<p><del>Revision of implantable intravenous infusion pump</del></p> <p><del>(36531 has been deleted. To report, see 36575-36578, 36581-36582, 36585-36585)</del></p>	010	N/A
36532		<p><del>Removal of implantable intravenous infusion pump</del>  <del>(If imaging guidance is performed, see 76000)</del></p> <p><del>(36532 has been deleted. To report, use 36590)</del></p>	010	N/A
36533		<p><del>Insertion of implantable venous access device, with or without subcutaneous reservoir</del>  <del>(For removal, use 36535)</del>  <del>(If imaging guidance is performed, see 76000, 76003, 76942)</del>  <del>(For refilling and maintenance of an implantable pump or reservoir for intravenous or intra-arterial drug delivery, use 96530)</del></p> <p><del>(36533 has been deleted. To report, see 36557-36558, 36560-36561, 36565-36566, 36570-36571)</del></p>	010	N/A
36534		<p><del>Revision of implantable venous access device and/or subcutaneous reservoir</del>  <del>(For removal, use 36535)</del></p> <p><del>(36534 has been deleted. To report, see 36575-36578, 36581-36583, 36585)</del></p>	010	N/A
36535		<p><del>Removal of implantable venous access device and/or subcutaneous reservoir</del>  <del>(Use 36535 in conjunction with codes 36533, 36534, as appropriate)</del>  <del>(Do not use 36535 in conjunction with codes 36488 36489 36490 36491)</del>  <del>(If imaging guidance is performed, use 76000)</del></p> <p><del>(36535 has been deleted. To report, use 36589)</del></p>	010	N/A

36536		<p><del>Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access</del></p> <p><del>(Do not report 36550 in addition to 36536)</del></p> <p><del>(For venous catheterization, see 36010-36012)</del></p> <p><del>(For radiological supervision and interpretation, use 75901)</del></p> <p><del>(36536 has been deleted. To report, use 36595)</del></p>	010	N/A
36537		<p><del>Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen</del></p> <p><del>(Do not report 36550 in addition to 36537)</del></p> <p><del>(For venous catheterization, see 36010-36012)</del></p> <p><del>(For radiological supervision and interpretation, use 75902)</del></p> <p><del>(36537 has been deleted. To report, use 36596)</del></p>	010	N/A

### Central Venous Access Procedures

To qualify as a central venous access catheter or device, the tip of the catheter/device must terminate in the subclavian, brachiocephalic (innominate) or iliac veins, the superior or inferior vena cava, or the right atrium. The venous access device may be either centrally inserted (jugular, subclavian, femoral vein or inferior vena cava catheter entry site) or peripherally inserted (eg, basilic or cephalic vein). The device may be accessed for use either via exposed catheter (external to the skin), via a subcutaneous port or via a subcutaneous pump.

The procedures involving these types of devices fall into five categories:

- 1) Insertion (placement of catheter through a newly established venous access)
- 2) Repair (fixing device without replacement of either catheter or port/pump, other than pharmacologic or mechanical correction of intracatheter or pericatheter occlusion (see 35695 or 365696 for those procedures))

- 3) Partial replacement of only the catheter component associated with a port/pump device, but not entire device.
- 4) Complete replacement of entire device via same venous access site (complete exchange).
- 5) Removal of entire device.

There is no coding distinction between venous access achieved percutaneously versus by cutdown or based on catheter size.

For the repair, partial (catheter only) replacement, complete replacement, or removal of both catheters (placed from separate venous access sites) of a multi-catheter device, with or without subcutaneous ports/pumps, use the appropriate code describing the service with a frequency of two.

If an existing central venous access device is removed and a new one placed via a separate venous access site, appropriate codes for both procedures (removal of old, if code exists, and insertion of new device) should be used.

When imaging is used for these procedures, either for gaining access to the venous entry site or for manipulating the catheter into final central position, use 75998, 76937).

<u>Insertion of Central Venous Access Device</u>				
●36555	L1	Insertion of non-tunneled centrally inserted central venous catheter; under 5 years of age <u>(For peripherally inserted non-tunneled central venous catheter, under 5 years of age, use 36568)</u>	000	2.68
●36556	L2	age 5 years or older <u>(For peripherally inserted non-tunneled central venous catheter, age 5 years or older, use 36569)</u>	000	2.50
●36557	L3	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; under 5 years of age	010	5.10
●36558	L4	age 5 years or older <u>(For peripherally inserted central venous catheter with port, 5 years or older, use 36571)</u>	010	4.80
●36560	L5	Insertion of tunneled centrally inserted central venous access device with subcutaneous port; under 5 years of age <u>(For peripherally inserted central venous access device with subcutaneous port, under 5 years of age, use 36570)</u>	010	6.25

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

●36561	L6	age 5 years or older (For peripherally inserted central venous catheter with port, 5 years or older, use 36571)	010	6.00
●36563	L7	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump	010	6.20
●36565	L8	Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; without subcutaneous port or pump, (eg, Tesio type catheter);	010	6.00
●36566	L9	with subcutaneous port(s)	010	6.50
●36568	L10	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, under 5 years of age <u>(For placement of centrally inserted non-tunneled central venous catheter, without subcutaneous port or pump, under 5 years of age, use 36555)</u>	000	1.92
●36569	L11	age 5 years or older <u>(For placement of centrally inserted non-tunneled central venous catheter, without subcutaneous port or pump, age 5 years or older, use 36556)</u>	000	1.82
●36570	L12	Insertion of peripherally inserted central venous access device with subcutaneous port; under 5 years of age <u>(For insertion of tunneled centrally inserted central venous access device with subcutaneous port, under 5 years of age, use 36560)</u>	010	5.32
●36571	L13	age 5 years or older <u>(For insertion of tunneled centrally inserted central venous access device with subcutaneous port, age 5 years or older, use 36561)</u>	010	5.30

<u>Repair of Central Venous Access Device</u>				
(For mechanical removal of pericatheter obstructive material, use 36595)				
(For mechanical removal of intracatheter obstructive material, use 36596)				
●36575	L14	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site	000	0.67
●36576	L15	Repair of central venous access device with subcutaneous port or pump, central or peripheral insertion site	010	3.19
<u>Partial Replacement of Central Venous Access Device (Catheter Only)</u>				
●36578	L16	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site  (For complete replacement of entire device through same venous access, use 36582 or 36583)	010	3.50
<u>Complete Replacement of Central Venous Access Device Through Same Venous Access Site</u>				
●36580	L17	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	000	1.31
●36581	L18	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	010	3.44
●36582	L19	Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous port, through same venous access	010	5.20
●36583	L20	Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous pump, through same venous access	010	5.25
●36584	L21	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access	000	1.20
●36585	L22	Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access	010	4.80

<u>Removal of Central Venous Access Device</u>				
●36589	L23	Removal of tunneled central venous catheter, without subcutaneous port or pump	010	2.27
●36590	L24	Removal of tunneled central venous access device with subcutaneous port or pump, central or peripheral insertion  <u>(Do not report codes 36589 or 36590 for removal of non-tunneled central venous catheters).</u>	010	3.30
<u>Mechanical Removal of Obstructed Material</u>				
●36595	L25	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access  (Do not report 36550 in addition to 36595)  (For venous catheterization, see 36010-36012)  (For radiological supervision and interpretation, use 75901)	010	3.60  (renumbered code 36536)
●36596	L26	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen  (Do not report 36550 in addition to 36596)  (For venous catheterization, see 36010-36012)  (For radiological supervision and interpretation, use 75902)	010	0.75  (renumbered code 36537)
<u>Other Central Venous Access Procedures</u>				
●36597	L29	Repositioning of previously placed central venous catheter under fluoroscopic guidance  (For fluoroscopic guidance use 76000)	000	1.21  (renumbered code – 36493)

Radiology				
75901		<p>Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation</p> <p>(For procedure, use <del>36536</del> <u>36595</u>)</p> <p>(For venous catheterization, see 36010-36012)</p>	XXX	0.49 (no change)
75902		<p>Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen, radiologic supervision and interpretation</p> <p>(For procedure, use <del>36537</del> <u>36596</u>)</p> <p>(For venous catheterization, see 36010-36012)</p>	XXX	0.39 (no change)
+●75998	L27	<p>Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List in addition to code for primary procedure)</p> <p>(Do not use 76003 with 75998)</p> <p><u>(If formal extremity venography performed from separate venous access and separately interpreted, use 36005 and 75820, 75822, 75825 or 75827)</u></p>	ZZZ	0.38
+●76937	L28	<p>Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)</p> <p>(Do not report 76937 in conjunction with 76942)</p> <p><u>(If extremity venous non-invasive vascular diagnostic study is performed separate from venous access guidance, use 93965, 93970 or 93971)</u></p>	ZZZ	0.30

(CVA) – Attachment A

Survey N and Reponse Distribution: Total and by Specialty

Track	CPT	TOTAL resp	Total N	ASA resp	ASA N	SIR resp	SIR N	ACR resp	ACR N	ACS APSA	Surg N
L1	36555	41	270	20	80	11	70	10	120		
L2	36556	56	280	32	90	14	70	10	120		
L3	36557	29	250			12	70	5	120	12	60
L4	36558	35	250			14	70	5	120	16	60
L5	36560	30	250			12	70	5	120	13	60
L6	36561	34	250			13	70	5	120	16	60
L7	36563	24	250			11	70	3	120	10	60
L8	36565	30	250			12	70	5	120	13	60
L9	36566	28	250			12	70	5	120	11	60
L10	36568	32	250			13	70	10	120	9	60
L11	36569	33	250			15	70	10	120	8	60
L12	36570	23	250			10	70	5	120	8	60
L13	36571	27	250			12	70	5	120	10	60
L14	36575	23	190			13	70	10	120		
L15	36576	16	190			11	70	5	120		
L16	36578	14	190			9	70	5	120		
L17	36580	40	250			14	70	10	120	16	60
L18	36581	17	190			12	70	5	120		
L19	36582	14	190			9	70	5	120		
L20	36583	13	190			8	70	5	120		
L21	36584	24	190			14	70	10	120		
L22	36585	14	190			9	70	5	120		
L23	36589	34	250			12	70	4	120	18	60
L24	36590	33	250			11	70	5	120	17	60

**(CVA) - Attachment B  
Comparison Data for Reference and Surveyed Codes**

New CPT Codes and References				Spec Rec'd RVW	SURVEY RVW					TIME SUMMARY				included in post time			
track	CPT	Description	glob		RVW min	RVW 25th	RVW med	RVW 75th	RVW max	PRE min	TIME intra	TIME post	TIME total	DD 38	OV 13	OV 12	OV 11
ref	36488	Placement of central venous catheter (subclavian, jugular, or other vein), (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy), percutaneous, age 2 years or under	0			1.35				9	24	9	42				
ref	36489	Placement of central venous catheter (subclavian, jugular, or other vein), (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy), percutaneous, over age 2	0			2.50				15	20	15	60				
ref	36533	Insertion of implantable venous access device, with or without subcutaneous reservoir	10			5.32				30	5	61	136	0.5	1.0		
ref	36534	Revision of implantable venous access device, and/or subcutaneous reservoir	10			2.80				16	52	30	98				
ref	36535	Removal of implantable venous access device, and/or subcutaneous reservoir	10			2.27				16	27	30	73				
L1	36555	Insertion of non-tunneled centrally inserted central venous catheter, under 5 years of age	0	2.68	1.35	2.00	2.50	3.00	10.00	30	20	10	60				
L2	36556	Insertion of non-tunneled centrally inserted central venous catheter, age 5 years or older	0	2.50	1.35	2.48	2.50	2.50	3.50	25	15	10	50				
L3	36557	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump, under 5 years of age	10	5.10	2.00	5.00	5.32	5.50	7.50	47	30	48	125	0.5		1	
L4	36558	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump, age 5 years or older	10	4.80	1.80	4.50	5.32	5.32	6.00	36	30	48	114	0.5		1	
L5	36560	Insertion of tunneled centrally inserted central venous access device with subcutaneous port; under 5 years of age	10	6.25	3.20	5.55	6.00	6.50	9.00	49	45	48	142	0.5		1	
L6	36561	Insertion of tunneled centrally inserted central venous access device with subcutaneous port, age 5 years or older	10	6.00	3.00	5.32	6.00	6.23	8.00	35	45	48	128	0.5		1	
L7	36563	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump	10	6.20	5.00	5.50	6.20	7.00	8.20	40	60	48	148	0.5		1	
L8	36565	Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites, without subcutaneous port or pump, (eg, Tesio type catheter),	10	6.00	4.00	5.50	5.78	6.88	8.05	35	45	48	128	0.5		1	
L9	36566	Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites, with subcutaneous port(s)	10	6.50	3.00	6.03	6.50	7.58	9.00	35	60	48	143	0.5		1	
L10	36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, under 5 years of age	0	1.92	0.64	2.00	2.54	3.08	6.25	30	20	10	60				
L11	36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, age 5 years or older	0	1.82	0.50	2.00	2.50	2.50	3.50	25	20	10	55				
L12	36570	Insertion of peripherally inserted central venous access device with subcutaneous port, under 5 years of age	10	5.32	2.50	5.32	5.50	6.32	9.00	50	45	48	143	0.5		1	
L13	36571	Insertion of peripherally inserted central venous access device with subcutaneous port, age 5 years or older	10	5.30	2.50	5.30	5.50	6.26	8.00	40	50	48	138	0.5		1	
L14	36575	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site	0	0.67	0.30	1.10	1.75	2.20	3.50	15	15	9	39				

**(CVA) - Attachment B  
Comparison Data for Reference and Surveyed Codes**

New CPT Codes and References				Spec Rec'd RVW	SURVEY RVW					TIME SUMMARY				included in post time			
track	CPT	Description	glob		RVW min	RVW 25th	RVW med	RVW 75th	RVW max	PRE min	TIME intra	TIME post	TIME total	DD 38	OV 13	OV 12	OV 11
ref	36488	Placement of central venous catheter (subclavian, jugular, or other vein), (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy), percutaneous, age 2 years or under	0			1.35			9	24	9	42					
ref	36489	Placement of central venous catheter (subclavian, jugular, or other vein), (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy), percutaneous, over age 2	0			2.50			15	20	15	60					
ref	36533	Insertion of implantable venous access device, with or without subcutaneous reservoir	10			5.32			30	5	61	136	0.5	1.0			
ref	36534	Revision of implantable venous access device, and/or subcutaneous reservoir	10			2.80			16	52	30	98					
ref	36535	Removal of implantable venous access device, and/or subcutaneous reservoir	10			2.27			16	27	30	73					
L15	36576	Repair of central venous access device with subcutaneous port or pump, central or peripheral insertion site	10	3.19	2.80	2.95	3.35	5.55	7.00	40	33	43	116	0.5		1	
L16	36578	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	10	3.50	2.75	3.09	4.50	5.50	7.00	36	30	45	111	0.5		1	
L17	36580	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	0	1.31	1.00	1.50	2.00	2.50	4.00	25	15	10	50				
L18	36581	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	10	3.44	1.50	2.80	3.00	3.50	5.50	35	30	43	108	0.5		1	
L19	36582	Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous port, through same venous access	10	5.20	3.38	4.25	5.73	6.24	8.00	46	60	45	151	0.5		1	
L20	36583	Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous pump, through same venous access	10	5.25	3.38	4.00	6.00	6.50	7.00	47	60	46	153	0.5		1	
L21	36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access	0	1.20	1.00	1.50	2.00	2.03	2.80	20	15	10	45				
L22	36585	Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access	10	4.80	3.38	4.00	5.75	6.32	8.00	26	60	46	132	0.5		1	
L23	36589	Removal of tunneled central venous catheter, without subcutaneous port or pump	10	2.27	1.00	1.63	2.27	2.30	5.50	25	13	35	73	0.5		1	
L24	36590	Removal of tunneled central venous access device with subcutaneous port or pump, central or peripheral insertion	10	3.30	1.50	2.27	2.80	3.75	5.70	29	30	48	107	0.5		1	

**(CVA) – Attachment C**

**Rationales for Work Relative Value Recommendations**

<b>track</b>	<b>CPT</b>	<b>Description</b>	<b>glob</b>	<b>RUC Rec'd RVW</b>	<b>Svy Med RVW</b>	<b>RVW Recommendation Rationale</b>
<b>L1</b>	<b>36555</b>	Insertion of non-tunneled centrally inserted central venous catheter; under 5 years of age	0	<b>2.68</b>	2.50	This service is similar to the existing code 36488, which was not surveyed at the 2 <sup>nd</sup> 5 YR review. This created a rank order anomaly with 36489. The current survey shows that the RVW should be increased at least equal to L2. The RUC agreed that this pediatric service should be valued higher than the corresponding adult service. The intensity was determined to be slightly higher in performing this service on a child younger than five years of age.
<b>L2</b>	<b>36556</b>	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	0	<b>2.50</b>	2.50	This service was previously described as 36489. Code 36489 was surveyed at the 2 <sup>nd</sup> Five-Year review and the RUC recommended a work value increase to 2.50. This survey re-confirms this previous RUC recommendation, which was linked to CPT code 36010 <i>Introduction of catheter, superior or inferior vena cava</i> (work RVU = 2.43).
<b>L3</b>	<b>36557</b>	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; under 5 years of age	10	<b>5.10</b>	5.32	The RUC recommends that this pediatric service be valued slightly higher than its adult counterpart (L4) and utilized the intensity from CPT code L1 to derive the work relative value, which is slightly lower than the survey median.
<b>L4</b>	<b>36558</b>	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older	10	<b>4.80</b>	5.32	The RUC recommends a work RVU less than the survey median. The intensity of 36489 was utilized to calculate the work recommendations for this service. This service was previously reported using CPT code 36533 (work RVU = 5.32).
<b>L5</b>	<b>36560</b>	Insertion of tunneled centrally inserted central venous access device with subcutaneous port; under 5 years of age	10	<b>6.25</b>	6.00	L5 and L6 include the work of "with port" compared with L3 and L4. The RUC agreed that the work for the pediatric patient should be greater and recommends a slightly higher work RVU, based on a greater intensity.
<b>L6</b>	<b>36561</b>	Insertion of tunneled centrally inserted central venous access device with subcutaneous port; age 5 years or older	10	<b>6.00</b>	6.00	L5 and L6 include the work of "with port" compared with L3 and L4. The survey median of 6.00 appeared appropriate. This reasonably accounts for the additional intra-time and overall intensity/complexity.

track	CPT	Description	glob	RUC Rec'd RVW	Svy Med RVW	RVW Recommendation Rationale
L7	36563	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump	10	6.20	6.20	The specialty recommended the survey median for L7. This code essentially replaces the existing CPT code 36533 (work RVU = 6.20), therefore, the RUC agreed that it should be valued the same.
L8	36565	Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; without subcutaneous port or pump, (eg, Tesio type catheter);	10	6.00	5.78	L8 includes the work of "insertion of an additional catheter" compared with L3 and L4. The specialty noted that this service was previously reported with CPT 36533, potentially with two units of service as this new code describes two access sites. The RUC agreed that a work relative value of 6.00 was appropriate to account for the increased work over L3/L4.
L9	36566	Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; with subcutaneous port(s)	10	6.50	6.50	L9 includes the work of "with port" compared with L8. The survey median of 6.50 was felt to be appropriate. An increment of 0.50 is a modest increment for the increased work of adding the port, however, the specialty indicated that there is a lower intensity in port placement.
L10	36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, under 5 years of age	0	1.92	2.54	L10 is comparable to L1, however, involves less complexity/intensity. The consensus committee believes L10 (PICC) which may be performed by a nurse should be valued less than L1 and recommends a value slightly less than the 25th percentile of 2.00. The RUC agreed that the work for the pediatric patient should be slightly higher than for the adult patient.
L11	36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older	0	1.82	2.50	L11 is comparable to L2, however, involves less complexity/intensity. The consensus committee believes L11 (PICC) which may be performed by a nurse should be valued less than L2 and recommends a value less than the 25th percentile of 2.00. The RUC reviewed the work value for this service and compared it to CPT code 93503 <i>Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes</i> (work RVU = 2.91, 30 minutes intra-service time) and determined that this insertion of a PICC line was valued appropriately relative to this service.
L12	36570	Insertion of peripherally inserted central venous access device with subcutaneous port; under 5 years of age	10	5.32	5.50	L12 (peripherally inserted) is less complex/intense than L5 (centrally inserted). The 25% of the survey reasonably reflects this difference. The work of this service is the same as existing code 36533 (5.32).

track	CPT	Description	glob	RUC Rec'd RVW	Svy Med RVW	RVW Recommendation Rationale
L13	36571	Insertion of peripherally inserted central venous access device with subcutaneous port; age 5 years or older	10	5.30	5.50	L13 (peripherally inserted) is less complex/intense than L6 (centrally inserted). The 25% of the survey reasonably reflects this difference. The 25% of the survey results reflects a slight decrease in work from the pediatric service.
L14	36575	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site	0	0.67	1.75	The specialty presented that L14 is most comparable with the work of 36537 (work RVU =0.75) or 99213 (work RVU = 0.67), and as such, the survey median of 1.75 is too high. The specialty also believed that the 25th percentile would be too high. Code 99213 was considered the best comparison and a "new" value of 0.67 is recommended for L14. This code describes a non-invasive, "hub repair." The intensity of this service is very low, however, the time is high as the physician must wait for the epoxy to cure.
L15	36576	Repair of central venous access device with subcutaneous port or pump, central or peripheral insertion site	10	3.19	3.35	L15 is the repair of L6. All of the work is the same, except for the initial needle stick and tunneling (L1/L2). The recommended RVW of 3.19 is approximately 55% of L6 (6.00) and reasonably accounts for this difference. This relationship also resembles the old relationship for 36533 and 36534 (5.32 vs. 2.80).
L16	36578	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	10	3.50	4.50	The RUC noted that the survey response for this code is very low (14) and the experience of those responding is also low (5). Because the median appears high, the RUC recommends using the logic presented for L15 to calculate a new RVW of 3.50 for L16. This value is approximately 55% of the "base" code L6 (0.55 x 6.00). The RUC also agreed with the specialties check of IWPUT at 0.050.
L17	36580	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	0	1.31	2.00	Using the logic presented for L15, L17 approximates 55% of the "base" code L2 (0.55 x 2.50). The IWPUT for this service was determined to be approximately 0.040.
L18	36581	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	10	3.44	3.00	L18 is the replacement of L4. All of the work is the same, except for the initial needle stick and tunneling (L1/L2). The IWPUT of this service was considered to be similar to the other replacement codes at 0.050. This relationship also resembles the old code pair 36533 and 36534 (5.32 vs. 2.80).

track	CPT	Description	glob	RUC Rec'd RVW	Svy Med RVW	RVW Recommendation Rationale
L19	36582	Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous port, through same venous access	10	5.20	5.73	The IWPUT of this service was considered to be similar to the other replacement codes at 0.050 and a work relative value was derived from this estimate.
L20	36583	Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous pump, through same venous access	10	5.25	6.00	The IWPUT of this service was considered to be similar to the other replacement codes at 0.050 and a work relative value was derived from this estimate.
L21	36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access	0	1.20	2.00	L21 should be slightly less work than to L17. Although "initial" insertion L10/L11 may be performed by a nurse and may be less complex/intense than L1/ L2, the "replacement" of a PICC would more likely be preformed by a physician and have an intensity/complexity compared with L17. The RUC also considered that the replacement of PICC should be valued less than a 99203, mid-level new patient office visit (work RVU =1.34).
L22	36585	Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access	10	4.80	5.75	The IWPUT of this service was considered to be similar to the other replacement codes at 0.050 and a work relative value was derived from this estimate.
L23	36589	Removal of tunneled central venous catheter, without subcutaneous port or pump	10	2.27	2.27	At an RVW of 2.27, L23 is approximately half as much work as L4. This service is the same service as the previous code 36535 (work RVU = 2.27). The RUC recommends the survey median of 2.27.
L24	36590	Removal of tunneled central venous access device with subcutaneous port or pump, central or peripheral insertion	10	3.30	2.80	At an RVW of 3.30, L24 is approximately half as much work as L5/L6. This service is the same service as the previous code 36532 (work RVU = 3.30).

track	CPT	Description	glob	RUC Rec'd RVW	Svy Med RVW	RVW Recommendation Rationale
L25	36595	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access	10	3.60	N/A	This new CPT code has simply been renumbered code 36536, which had been recently surveyed by the RUC. The RUC recommends no change in the work relative value.
L26	36596	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen	10	0.75	N/A	This new CPT code has simply been renumbered code 36537, which had been recently surveyed by the RUC. The RUC recommends no change in the work relative value.
L29	36597	Repositioning of previously placed central venous catheter under fluoroscopic guidance	000	1.21	2.00	This new CPT code has simply been renumbered code 36493. The code was also surveyed as part of this overall issue. Although the survey median reflects a higher value, the RUC recommends no change in the work relative value.
L27	75998	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List in addition to code for primary procedure)	ZZZ	0.38	0.70	The specialty determined the survey median and the 25% of the survey were too high. The specialty compared the work of this service to codes 76000 <i>Fluoroscopy (separate procedure)</i> (work RVU =0.17, 5 minutes of intra-service, IWPUT = .034) and 76003 <i>Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)</i> (work RVU = 0.54, 12 minutes of intra-service time, IWPUT = 0.045). This service has a intra-service time of 9 minutes, in comparison to both of these codes, the RUC agreed that a work relative value of 0.38 was reasonable. The specialty did indicate that 76XXX will be reported in addition to CPT code 7694X when ultrasound is required to find the vein and fluoroscopic guidance is required for placement of the catheter.

track	CPT	Description	glob	RUC Rec'd RVW	Svy Med RVW	<i>RVW Recommendation Rationale</i>
L28	76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)	ZZZ	0.30	0.70	The specialty determined that the survey median and the 25% of the survey were too high. The specialty used the IWPUT of CPT code 76945 <i>Ultrasound guidance for chorionic villus sample, imaging supervision and interpretation</i> (work RVU = .67, intra-service 20 minutes, IWPUT = .033) and compared it to the 10 minutes of intra-service time for L28 to approximate a work relative value recommendation of 0.30.

Estimated Medicare Utilization - Work Neutrality Calculation

	A	B	C	D	G	H	I	J	K	L	M	N	O	P
1	2003 CODES				2001 IMPACT UTIL	EST. NEW FREQ SPLIT		2003 WORK- RVUs	2004 WORK- RVUs	REC RVW	NEW CODE I/PUT	2004 CODES		
2								3,557,222	3,100,303					
3	<b>PLACE CENTRAL CATHETER UNDER AGE 5</b>				1,451	1,451		1,976	3,392					
4	36488	Placement of CV catheter (subclavian, jugular, or other vein) (eg, for CV pressure, hyperal, hemodialysis, or chemo), percut, age 2 yrs or under	1.35	0	1,397	55%	798	1,886	2,139	2.68	0.093	L1	36555	Insertion of non-tunneled centrally inserted central venous catheter, under 5 years of age
5	36490	Placement of CV catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy), cutdown, age 2 years or under	1.67	0	54	45%	653	90	1,254	1.92	0.055	L10	36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, under 5 years of age
6														
7	<b>PLACE OR REPLACE CENTRAL CATHETER OVER AGE 5</b>				863,562	863,562		2,141,395	1,669,439					
8	36489	Placement of CV catheter (subclavian, jugular, or other vein) (eg, for CV pressure, hyperal, hemodialysis, or chemo), percut, over age 2	2.50	0	847,198	36%	310,882	2,117,994	777,206	2.50	0.091	L2	36553	Insertion of non-tunneled centrally inserted central venous catheter, age 5 years or older
9	36491	Placement of CV catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy), cutdown, over age 2	1.43	0	16,365	10%	86,356	23,401	113,127	1.31	0.040	L17	36580	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
10						41%	354,060		644,390	1.82	0.055	L11	36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, age 5 years or older
11						13%	112,263		134,716	1.20	0.040	L21	36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access
12														
13	<b>INSERT PUMP</b>				381	381		2,359	2,359					
14	36530	Insertion of implantable intravenous infusion pump	6.20	10	381	100%	381	2,359	2,359	6.20	0.067	L7	36563	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump
15														
16	<b>INSERT TUNNEL OR NON-TUNNEL DEVICE W/WO PORT</b>				212,444	212,444		1,130,204	1,136,938					
17	36533	Insertion of implantable venous access device, with or without subcutaneous reservoir	5.32	10	212,444	3%	6,373	1,130,204	32,504	5.10	0.093	L3	36557	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump, under 5 years of age

Estimated Medicare Utilization - Work Neutrality Calculation

	A	B	C	D	G	H	I	J	K	L	M	N	O	P
1	2003 CODES				2001 IMPACT UTIL	EST. NEW FREQ SPLIT		2003 WORK- RVUs	2004 WORK- RVUs	REC RVW	NEW CODE I/PUT	2004 CODES		
18						47%	99,849		479,274	4.80	0.091	L4	36558	Insertion of tunneled centrally inserted central venous catheter, <b>without subcutaneous port or pump</b> , age 5 years or older
19						3%	6,373		39,833	6.25	0.087	L5	36560	Insertion of tunneled centrally inserted central venous access device <b>with subcutaneous port</b> , under 5 years of age
20						33%	70,107		420,640	6.00	0.088	L6	36561	Insertion of tunneled centrally inserted central venous access device <b>with subcutaneous port</b> , age 5 years or older
21						3%	6,373		38,240	6.00	0.088	L8	36565	Insertion of tunneled centrally inserted central venous access device, requiring <b>two catheters</b> via two separate venous access sites, <b>without subcutaneous port or pump</b> (eg, Tesio type catheter),
22						1%	2,124		13,809	6.50	0.074	L9	36566	Insertion of tunneled centrally inserted central venous access device, requiring <b>two catheters</b> via two separate venous access sites, <b>with subcutaneous port(s)</b>
23						1%	2,124		11,302	5.32	0.065	L12	36570	Insertion of <b>peripherally</b> inserted central venous access device <b>with subcutaneous port</b> ; under 5 years of age
24						9%	19,120		101,336	5.30	0.063	L13	36571	Insertion of <b>peripherally</b> inserted central venous access device <b>with subcutaneous port</b> , age 5 years or older
25														
26	<b>REPAIR / REPLACE DEVICE WWO PORT OR PUMP</b>				17,341	17,341		48,622	55,508					
27	36531	Revision of implantable intravenous infusion pump	4.87	10	33	16%	2,774	161	1,859	0.67	0.014	L14	36575	Repair of tunneled or non-tunneled central venous access catheter, <b>without subcutaneous port or pump</b> , central or peripheral insertion site
28	36534	Revision of implantable venous access device, and/or subcutaneous reservoir	2.80	10	17,308	12%	2,081	48,461	6,638	3.19	0.035	L15	36576	Repair of central venous access device <b>with subcutaneous port or pump</b> , central or peripheral insertion site
29						12%	2,081		7,283	3.50	0.050	L16	36578	Replacement, catheter only, of central venous access device, <b>with subcutaneous port or pump</b> , central or peripheral insertion site

CVA - Attachment D

Estimated Medicare Utilization - Work Neutrality Calculation

	A	B	C	D	G	H	I	J	K	L	M	N	O	P
1	2003 CODES				2001 IMPACT UTIL	EST. NEW FREQ SPLIT		2003 WORK-RVUs	2004 WORK-RVUs	REC RVW	NEW CODE I/PUT	2004 CODES		
						47%	8,150		28,036	3.44	0.050	L18	36581	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
30						12%	2,081		10,820	5.20	0.050	L19	36582	Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous port, through same venous access
31						1%	87		455	5.25	0.050	L20	36583	Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous pump, through same venous access
32						1%	87		416	4.80	0.050	L22	36585	Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access
33														
34														
35	<b>REMOVE CATHETER WITHOUT PORT / PUMP</b>				95,725	95,725		217,295	217,295					
36	36535	Removal of implantable venous access device, and/or subcutaneous reservoir	2.27	10	95,725	100%	95,725	217,295	217,295	2.27	0.061	L23	36589	Removal of tunneled central venous catheter, without subcutaneous port or pump
37														
38	<b>REMOVE DEVICE WITH PORT / PUMP</b>				787	787		2,595	2,595					
39	36532	Removal of implantable intravenous infusion pump	3.30	10	787	100%	787	2,595	2,595	3.30	0.046	L24	36590	Removal of tunneled central venous access device with subcutaneous port or pump, central or peripheral insertion
40														
41	<b>MISCELLANEOUS</b>													
42	36493	Repositioning of previously placed central venous catheter under fluoroscopic guidance	1.21	0	10,559	100%	10,559	12,776	12,776	1.21	0.033		36597	Repositioning of previously placed central venous catheter under fluoroscopic guidance

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

(Apr. 2003)

**CPT Code:** 36555    **Tracking No:** L1    **Global:** 000    **Recommended RVW:** 2.68

**Descriptor:** Insertion of non-tunneled centrally inserted central venous catheter; under 5 years of age

**SURVEY Vignette (Typical Patient)**

A 2 year-old male needs a central venous catheter. A percutaneous non-tunneled centrally inserted central venous catheter is inserted.

**Clinical Description Of Service:**

**Pre-service:** The procedure is explained to the patient's parents and consent obtained. Prior medical records, including any history of prior CV catheter placements/attempts, are reviewed. Arrangements are made with OR/angio suite and anesthesia. Physician assists with patient positioning and scrubs in standard fashion. After gowning, access site is prepped and draped in usual fashion.

**Intra-service:** Local lidocaine anesthesia is administered. The subclavian/jugular vein is punctured and a guidewire passed centrally. The CV catheter is then placed. The catheter is sutured in position and dressed in standard fashion, and attached to IV infusion fluids.

**Post service:** Orders are written for catheter care as well as for portable CXR. Catheter position is confirmed and no pneumothorax is detected. Catheter and insertion site wound care is prescribed. A note is placed in the patient chart and report dictated.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	American Society of Anesthesiologists; Karl Becker, MD Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36555				
<b>Sample Size:</b>	270	<b>Resp n:</b>	41	<b>Resp %:</b>	15%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.35	2.00	2.50	3.00	10.00
<b>Pre-Service Evaluation Time:</b>			20		
<b>Pre-Service Positioning Time:</b>			5		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5		
<b>Intra-Service Time:</b>	10	15	20	30	60
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	10				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	0				
<b>Office time/visit(s):</b>	0				

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19), 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36488	Placement of central venous catheter (subclavian, jugular, or other vein), (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy), percutaneous, age 2 years or under	1.35	0

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

	Svy CPT 36555	Ref CPT 36488 hvd
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	41	--
Pre-service	30	9
Intra-service	20	24
Same Day Immediate Post-service	10	9
Critical care	0	0
Other hospital visit	0	0
Discharge day management	0	0
Office visit	0	0
<i>TOTAL TIME</i>	<i>60</i>	<i>42</i>

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	22	22
--------------------------	----	----

**TIME SEGMENTS**

Pre-service	2.38	2.40
Intra-service	3.38	2.55
Post-service	2.30	2.81

**MENTALEFFORTANDJUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	3.57	2.37
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.67	2.42
Urgency of medical decision making	3.43	2.70

**TECHNICALSKILL/PHYSICALEFFORT**

Technical skill required	3.71	3.55
Physical effort required	3.52	2.65

**PSYCHOLOGICALSTRESS**

The risk of significant complications, morbidity and/or mortality	2.24	3.50
Outcome depends on the skill and judgment of physician	3.24	3.65
Estimated risk of final practice suit with poor outcome	2.20	3.50

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

(Apr. 2003)

**CPT Code:** 36556      **Tracking No:** L2      **Global:** 000      **Recommended RVW:** 2.50

**Descriptor:** Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

**SURVEY Vignette (Typical Patient)**

A 40 year-old female needs a central venous catheter. A centrally inserted, non-tunneled, central venous catheter is inserted.

**Clinical Description Of Service:**

**Pre service:** The procedure is explained to the patient and consent obtained. Prior medical records, including any history of prior CV catheter placements/attempts, are reviewed. Physician assists with patient positioning and scrubs in standard fashion. The access site is prepped and draped in standard fashion.

**Intra service:** Local lidocaine anesthesia is administered. The subclavian/internal jugular vein is punctured and a guidewire passed centrally. The venotomy site is dilated to the appropriate size and the CV catheter is then placed. The catheter is sutured in position and dressed in standard fashion, and flushed or attached to IV infusion fluids.

**Post service:** Orders are written for catheter care as well as for portable CXR. Catheter position is confirmed and no pneumothorax is detected. A note is placed in the patient's chart and report dictated.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	American Society of Anesthesiologists; Karl Becker, MD Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36556				
<b>Sample Size:</b>	280	<b>Resp n:</b>	56	<b>Resp %:</b>	20%
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.35	2.48	2.50	2.50	3.50
<b>Pre-Service Evaluation Time:</b>			15		
<b>Pre-Service Positioning Time:</b>			5		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5		
<b>Intra-Service Time:</b>	7	10	15	20	45
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	10				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	0				
<b>Office time/visit(s):</b>	0				

\*Physician standard total minutes per E/M visit: 99291 (60), 99292 (30); 99233 (41), 99232 (30); 99231 (19); 99238 (36); 99215 (59), 99214 (38); 99213 (23), 99212 (15), 99211 (7)

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36489	Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2	2 50	0

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

	Svy CPT 36556	Ref CPT 36489 2 <sup>nd</sup> 5-YR
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	56	--
Pre-service	25	15
Intra-service	15	20
Same Day Immediate Post-service	10	15
Critical care	0	0
Other hospital visit	0	0
Discharge day management	0	0
Office visit	0	0
<i>TOTAL TIME</i>	50	50

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	43	43
--------------------------	----	----

**TIME SEGMENTS**

Pre-service	2.05	2.05
Intra-service	2.66	2.23
Post-service	1.83	2.34

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	2.59	2.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.22	2.21
Urgency of medical decision making	2.23	2.35

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	2.72	3.08
Physical effort required	2.29	2.50

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	2.14	2.88
Outcome depends on the skill and judgment of physician	2.65	3.10
Estimated risk of malpractice suit with poor outcome	1.92	2.60

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

(Apr. 2003)

**CPT Code:** 36557      **Tracking No:** L3      **Global:** 010      **Recommended RVW:** 5.10

**Descriptor:** Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; under 5 years of age

**SURVEY Vignette (Typical Patient)**

A 12-month-old girl requires long term central venous access. A centrally inserted tunneled central venous catheter is inserted.

**Clinical Description Of Service:**

**Pre-service:** The procedure is explained to the patient's parents and consent obtained. Prior medical records, including any history of prior CV catheter placements/attempts, are reviewed. Arrangements are made with OR/angio suite and anesthesia. Physician assists with patient positioning and scrubs in standard fashion. After gowning, access site is prepped and draped in usual fashion

**Intra service:** Local lidocaine anesthesia is administered. A percutaneous or cut down approach is used in the neck and venous access achieved. A subcutaneous tunnel is then created from the anterior chest wall to the venotomy site and catheter passed through the tunnel. The CV catheter is then placed. The catheter is sutured in position and the skin incisions are sutured as needed. The wounds are dressed in standard fashion, and catheter ports attached to IV infusion fluids.

**Post service:** Orders are written for IV fluids and catheter care as well as for portable CXR. Catheter position is confirmed and no pneumothorax is seen. A note is placed in the patient's chart and report dictated. The patient is seen in the office for wound check.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	American College of Surgeons; Charles Mabry, MD, FACS American Pediatric Surgical Association; Samuel Smith, MD, FACS Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36557				
<b>Sample Size:</b>	250	<b>Resp n:</b>	29	<b>Resp %:</b>	12%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	2.00	5.00	5.32	5.50	7.50
<b>Pre-Service Evaluation Time:</b>			30		
<b>Pre-Service Positioning Time:</b>			7		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10		
<b>Intra-Service Time:</b>	15	30	30	40	50
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	18	99238 x 0.5			
<b>Office time/visit(s):</b>	15	99212 x 1			

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36533	Insertion of implantable venous access device, with or without subcutaneous reservoir	5.32	10

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

	Svy CPT 36557	Ref CPT 36533 1 <sup>st</sup> 5-YR
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	29	36
Pre-service	47	30
Intra-service	30	45
Same Day Immediate Post-service	15	20
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	18
Office visit	15	23
<i>TOTAL TIME</i>	125	136

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	26	26
--------------------------	----	----

**TIME SEGMENTS**

Pre-service	2.43	2.61
Intra-service	2.91	2.52
Post-service	2.13	2.17

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	2.70	2.39
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.39	2.26
Urgency of medical decision making	2.48	2.22

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	3.09	3.09
Physical effort required	2.78	2.61

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	2.57	2.70
Outcome depends on the skill and judgment of physician	3.04	2.96
Estimated risk of malpractice suit with poor outcome	2.39	2.87

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

(Apr. 2003)

**CPT Code:** 36558      **Tracking No:** L4      **Global:** 010      **Recommended RVW:** 4.80

**Descriptor:** Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older

**SURVEY Vignette (Typical Patient)**

A 55 year-old male needs long term central venous access. A tunneled centrally inserted central venous dialysis catheter is placed.

**Clinical Description Of Service:**

**Pre service:** The procedure is explained to the patient and consent obtained. Prior medical records, including labs and any history of prior CV catheter placements/attempts, are reviewed. Physician assists with patient positioning and scrubs in standard fashion. After gowning, access site is prepped and draped in usual fashion.

**Intra service:** Local lidocaine anesthesia is administered. The subclavian/internal jugular vein is punctured and a guidewire passed centrally. A subcutaneous tunnel is then created from the anterior chest wall to the venotomy site and catheter passed through the tunnel. The venotomy site is dilated to the appropriate size and the CV catheter is then placed. The catheter is sutured in position and the skin incisions are sutured as needed. The wounds are dressed in standard fashion, and catheter ports flushed or attached to IV infusion fluids.

**Post service:** Orders are written for IV fluids, catheter care as well as for portable CXR. Catheter position is confirmed and no pneumothorax is seen. A note is placed in the patient chart and report dictated. The patient is seen in the office for wound check.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	American College of Surgeons; Charles Mabry, MD, FACS American Pediatric Surgical Association; Samuel Smith, MD, FACS Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36558				
<b>Sample Size:</b>	250	<b>Resp n:</b>	35	<b>Resp %:</b>	14%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.80	4.50	5.32	5.32	6.00
<b>Pre-Service Evaluation Time:</b>			20		
<b>Pre-Service Positioning Time:</b>			6		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10		
<b>Intra-Service Time:</b>	10	25	30	40	50
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	18	99238 x 0.5			
<b>Office time/visit(s):</b>	15	99212 x 1			

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19), 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36533	Insertion of implantable venous access device, with or without subcutaneous reservoir	5.32	10

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

	Svy CPT 36558	Ref CPT 36533
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	35	36
Pre-service	36	30
Intra-service	30	45
Same Day Immediate Post-service	15	20
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	18
Office visit	15	23
<i>TOTAL TIME</i>	114	136

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	32	32
--------------------------	----	----

**TIME SEGMENTS**

Pre-service	2.29	2.39
Intra-service	2.75	2.61
Post-service	1.93	2.07

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	2.55	2.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.34	2.28
Urgency of medical decision making	2.34	2.14

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	2.86	2.93
Physical effort required	2.34	2.45

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	2.41	2.52
Outcome depends on the skill and judgment of physician	2.86	2.90
Estimated risk of malpractice suit with poor outcome	2.24	2.55

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

(Apr. 2003)

**CPT Code:** 36560      **Tracking No:** L5      **Global:** 010      **Recommended RVW:** 6.25

**Descriptor:** Insertion of tunneled centrally inserted central venous access device with subcutaneous port; under 5 years of age

**SURVEY Vignette (Typical Patient)**

A 3 year-old male is admitted and requires long term central venous catheter. A tunneled centrally inserted central venous catheter with a subcutaneous port is inserted.

**Clinical Description Of Service:**

Pre service: The procedure is explained to the patient's parents and consent obtained. Prior medical records, including any history of prior CV catheter placements/attempts, are reviewed. Arrangements are made with OR/angio suite and with anesthesia. Physician assists with patient positioning and scrubs in standard fashion. After gowning, access site is prepped and draped in usual fashion.

Intra service: Local lidocaine anesthesia is administered. The subclavian/internal jugular vein is punctured and a guidewire passed centrally. A subcutaneous pocket and tunnel are then created from the anterior chest wall to the venotomy site and catheter passed through the tunnel. The CV catheter is then placed. The catheter is connected to the port device and connection checked with injection. The port is secured in the chest wall pocket. The skin incisions are sutured. The wounds are dressed in standard fashion.

Post service: Orders are written for port flushing and portable CXR. Wound care is prescribed. Catheter position is confirmed and no pneumothorax is detected. A note is placed in the patient chart and report dictated. The patient is seen in the office to check the wounds.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	American College of Surgeons; Charles Mabry, MD, FACS American Pediatric Surgical Association; Samuel Smith, MD, FACS Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36560				
<b>Sample Size:</b>	250	<b>Resp n:</b>	30	<b>Resp %:</b>	12%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	3.20	5.55	6.00	6.50	9.00
<b>Pre-Service Evaluation Time:</b>			30		
<b>Pre-Service Positioning Time:</b>			9		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10		
<b>Intra-Service Time:</b>	20	37	45	60	90
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	18	99238 x 0.5			
<b>Office time/visit(s):</b>	15	99212 x 1			

\*Physician standard total minutes per E/M visit. 99291 (60), 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23), 99212 (15), 99211 (7)

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36533	Insertion of implantable venous access device, with or without subcutaneous reservoir	5.32	10

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

	Svy CPT 36560	Ref CPT 36533 1 <sup>st</sup> 5-YR
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	30	36
Pre-service	49	30
Intra-service	45	45
Same Day Immediate Post-service	15	20
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	18
Office visit	15	23
<i>TOTAL TIME</i>	<i>142</i>	<i>136</i>

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	26	26
--------------------------	----	----

**TIME SEGMENTS**

Pre-service	2.55	2.50
Intra-service	3.41	2.64
Post-service	2.32	2.23

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	2.87	2.35
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.43	2.22
Urgency of medical decision making	2.52	2.09

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	3.26	3.13
Physical effort required	2.91	2.65

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	2.61	2.74
Outcome depends on the skill and judgment of physician	3.13	3.00
Estimated risk of malpractice suit with poor outcome	2.41	2.70

**ADDITIONAL RATIONALE** - See Attachments B and C

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

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

(Apr. 2003)

**CPT Code:** 36561      **Tracking No:** L6      **Global:** 010      **Recommended RVW:** 6.00

**Descriptor:** Insertion of tunneled centrally inserted central venous access device with subcutaneous port; age 5 years or older

**SURVEY Vignette (Typical Patient)**

A 45 year-old female requires long term central venous access. A tunneled centrally inserted central venous catheter with subcutaneous port is inserted.

**Clinical Description Of Service:**

**Pre service:** The procedure is explained to the patient and consent obtained. Prior medical records, including any history of prior CV catheter placements/attempts, are reviewed. Arrangements are made with OR/angio suite. Physician assists with patient positioning and scrubs in standard fashion. After gowning, access site is prepped and draped in usual fashion

**Intra service:** Local lidocaine anesthesia is administered. The internal jugular/subclavian vein is punctured and a guidewire passed centrally. A subcutaneous pocket and tunnel are then created from the anterior chest wall to the venotomy site and catheter passed through the tunnel. The CV catheter is then placed. The catheter is connected to the port device and connection checked with injection. The port is secured in the chest wall pocket. The skin incisions are sutured. The wounds are dressed in standard fashion.

**Post service:** Orders are written for port flushing and portable CXR. Wound care is prescribed. Catheter position is confirmed and no pneumothorax is detected. A note is placed in the patient chart and report dictated. The patient is seen in the office to check the wounds.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	American College of Surgeons; Charles Mabry, MD, FACS American Pediatric Surgical Association; Samuel Smith, MD, FACS Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36561				
<b>Sample Size:</b>	250	<b>Resp n:</b>	34	<b>Resp %:</b>	14%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	3.00	5.32	6.00	6.23	8.00
<b>Pre-Service Evaluation Time:</b>			20		
<b>Pre-Service Positioning Time:</b>			5		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10		
<b>Intra-Service Time:</b>	15	30	45	60	90
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	18	99238 x 0.5			
<b>Office time/visit(s):</b>	15	99212 x 1			

\*Physician standard total minutes per E/M visit. 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7)

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36533	Insertion of implantable venous access device, with or without subcutaneous reservoir	5 32	10

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

	Svy CPT 36561	Ref CPT 36533
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	34	36
Pre-service	35	30
Intra-service	45	45
Same Day Immediate Post-service	15	20
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	18
Office visit	15	23
<i>TOTAL TIME</i>	<i>128</i>	<i>136</i>

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	30	30
--------------------------	----	----

**TIME SEGMENTS**

Pre-service	2.37	2.41
Intra-service	3.07	2.52
Post-service	2.19	2.00

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	2.79	2.34
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.45	2.17
Urgency of medical decision making	2.41	1.97

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	3.00	3.00
Physical effort required	2.52	2.45

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	2.48	2.59
Outcome depends on the skill and judgment of physician	3.03	2.93
Estimated risk of malpractice suit with poor outcome	2.14	2.48

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

(Apr. 2003)

**CPT Code:** 36563      **Tracking No:** L7      **Global:** 010      **Recommended RVW:** 6.20

**Descriptor:** Insertion of tunneled centrally inserted central venous access device with subcutaneous pump

**SURVEY Vignette (Typical Patient)**

A 57 year old male requires long term central venous therapy. A central venous catheter with subcutaneous pump is placed.

**Clinical Description Of Service:**

**Pre service:** The procedure is explained to the patient and consent obtained. Prior medical records, including any history of prior CV catheter placements/attempts, are reviewed. Arrangements are made with OR/angio suite. Physician assists with patient positioning and scrubs in standard fashion. After gowning, access site is prepped and draped in usual fashion.

**Intra service:** Local lidocaine anesthesia is administered. The subclavian/internal jugular vein is punctured and a guidewire passed centrally. A subcutaneous pocket and tunnel are then created from the anterior chest wall to the venotomy site and catheter passed through the tunnel. The CV catheter is then placed. The catheter is connected to the pump device and connection checked with injection. The pump is secured in the chest wall pocket. The skin incisions are sutured. The wounds are dressed in standard fashion.

**Post service:** Orders are written for pump care and portable CXR. Wound care is prescribed. Catheter position is confirmed and no pneumothorax is detected. A note is placed in the patient chart and report dictated. The patient is seen in the office to check the wounds.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	American College of Surgeons; Charles Mabry, MD, FACS American Pediatric Surgical Association; Samuel Smith, MD, FACS Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36563				
<b>Sample Size:</b>	250	<b>Resp n:</b>	24	<b>Resp %:</b>	10%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	5.00	5.50	6.20	7.00	8.20
<b>Pre-Service Evaluation Time:</b>			20		
<b>Pre-Service Positioning Time:</b>			10		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10		
<b>Intra-Service Time:</b>	25	45	60	63	90
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	18	99238 x 0.5			
<b>Office time/visit(s):</b>	15	99212 x 1			

\*Physician standard total minutes per E/M visit: 99291 (60), 99292 (30), 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7)

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36533	Insertion of implantable venous access device, with or without subcutaneous reservoir	5.32	10

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

	Svy CPT 36563	Ref CPT 36533 1 <sup>st</sup> 5-YR
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	24	36
Pre-service	40	30
Intra-service	60	45
Same Day Immediate Post-service	15	20
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	18
Office visit	15	23
<i>TOTAL TIME</i>	148	136

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	17	17
--------------------------	----	----

**TIME SEGMENTS**

Pre-service	2.40	2.73
Intra-service	3.27	2.47
Post-service	2.27	2.13

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	3.27	2.47
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.53	2.13
Urgency of medical decision making	2.73	2.00

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	3.13	3.13
Physical effort required	2.80	2.47

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	2.33	2.53
Outcome depends on the skill and judgment of physician	3.13	3.07
Estimated risk of malpractice suit with poor outcome	1.93	2.60

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

(Apr. 2003)

**CPT Code:** 36565      **Tracking No:** L8      **Global:** 010      **Recommended RVW:** 6.00

**Descriptor:** Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; without subcutaneous port or pump, (e.g. Tesio type catheter);

**SURVEY Vignette (Typical Patient)**

A 55 year old male with end stage renal disease is referred for a tunneled CV access device. Decision is made to place a two-catheter system via separate venous access sites.

**Clinical Description Of Service:**

**Pre service:** The procedure is explained to the patient and consent obtained. Prior medical records, including any history of prior CV catheter placements/attempts, are reviewed. Arrangements are made with OR/angio suite. Physician assists with patient positioning and scrubs in standard fashion. After gowning, access site is prepped and draped in usual fashion.

**Intra service:** Local lidocaine anesthesia is administered. For each catheter and access site, the internal jugular vein is punctured and a guidewire passed centrally. Two subcutaneous tunnels are created from the anterior chest wall to the venotomy sites and catheters passed through the tunnels. Both venotomy sites are dilated to appropriate size. The CV catheters are then placed. The catheters are sutured in position. The skin incisions are sutured. The wounds are dressed in standard fashion and catheters flushed.

**Post service:** Orders are written for catheter flushing and portable CXR. Wound care is prescribed. Catheter positions are confirmed and no pneumothorax is detected. A note is placed in the patient chart and report dictated. The patient is seen in the office to check the wounds.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	American College of Surgeons; Charles Mabry, MD, FACS American Pediatric Surgical Association; Samuel Smith, MD, FACS Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36565				
<b>Sample Size:</b>	250	<b>Resp n:</b>	30	<b>Resp %:</b>	12%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	4.00	5.50	5.78	6.88	8.05
<b>Pre-Service Evaluation Time:</b>			20		
<b>Pre-Service Positioning Time:</b>			5		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10		
<b>Intra-Service Time:</b>	20	36	45	58	75
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	18	99238 x 0.5			
<b>Office time/visit(s):</b>	15	99212 x 1			

\*Physician standard total minutes per E/M visit: 99291 (60), 99292 (30); 99233 (41); 99232 (30), 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7)

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36533	Insertion of implantable venous access device, with or without subcutaneous reservoir	5.32	10

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

	Svy CPT 36565	Ref CPT 36533 1 <sup>st</sup> 5-YR
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	30	36
Pre-service	35	30
Intra-service	45	45
Same Day Immediate Post-service	15	20
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	18
Office visit	15	23
<i>TOTAL TIME</i>	128	136

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	25	25
--------------------------	----	----

**TIME SEGMENTS**

Pre-service	2.61	2.57
Intra-service	3.22	2.52
Post-service	2.22	2.13

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	2.96	2.46
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.83	2.29
Urgency of medical decision making	2.67	2.13

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	3.17	3.00
Physical effort required	2.71	2.50

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	2.71	2.67
Outcome depends on the skill and judgment of physician	3.08	2.79
Estimated risk of malpractice suit with poor outcome	2.42	2.63

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

(Apr. 2003)

**CPT Code:** 36566      **Tracking No:** L9      **Global:** 010      **Recommended RVW:** 6.50

**Descriptor:** Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; with subcutaneous port(s)

**SURVEY Vignette (Typical Patient)**

61 year-old female chronic renal failure patient requires long term catheter access for dialysis. She is referred for placement of a multicatheter multiport central venous dialysis system for anticipated long-term use.

**Clinical Description Of Service:**

**Pre service:** The procedure is explained to the patient and consent obtained. Prior medical records, including any history of prior CV catheter placements/attempts, are reviewed. Arrangements are made with OR/angio suite. Physician assists with patient positioning and scrubs in standard fashion. After gowning, access site is prepped and draped in usual fashion.

**Intra service:** Local lidocaine anesthesia is administered. For each catheter and access site, the internal jugular vein is punctured and a guidewire passed centrally. Two subcutaneous pockets and tunnels from the anterior chest wall to the venotomy sites are created and catheters passed through the tunnels. Both venotomy sites are dilated to appropriate size. The CV catheters are then placed. The catheters are attached to their respective port devices and the connections checked by injection. The ports are secured in the chest wall pockets. The skin incisions are sutured. The wounds are dressed in standard fashion.

**Post service:** Orders are written for port flushing and portable CXR. Wound care is prescribed. Catheter positions are confirmed and no pneumothorax is detected. A note is placed in the patient chart and report dictated. The patient is seen in the office to check the wounds.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	American College of Surgeons; Charles Mabry, MD, FACS American Pediatric Surgical Association; Samuel Smith, MD, FACS Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36566				
<b>Sample Size:</b>	250	<b>Resp n:</b>	28	<b>Resp %:</b>	11%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	3.00	6.03	6.50	7.58	9.00
<b>Pre-Service Evaluation Time:</b>			20		
<b>Pre-Service Positioning Time:</b>			5		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10		
<b>Intra-Service Time:</b>	20	45	60	71	120
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	18	99238 x 0.5			
<b>Office time/visit(s):</b>	15	99212 x 1			

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38), 99213 (23), 99212 (15), 99211 (7)

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36533	Insertion of implantable venous access device, with or without subcutaneous reservoir	5.32	10

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

	Svy CPT 36566	Ref CPT 36533 1 <sup>st</sup> 5-YR
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	28	36
Pre-service	35	30
Intra-service	60	45
Same Day Immediate Post-service	15	20
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	18
Office visit	15	23
<i>TOTAL TIME</i>	143	136

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	21	21
--------------------------	----	----

**TIME SEGMENTS**

Pre-service	2.37	2.37
Intra-service	3.21	2.42
Post-service	2.16	1.95

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	2.95	2.26
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.68	2.05
Urgency of medical decision making	2.63	1.89

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	3.00	2.79
Physical effort required	2.47	2.21

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	2.40	2.37
Outcome depends on the skill and judgment of physician	3.00	2.63
Estimated risk of malpractice suit with poor outcome	2.15	2.37

---

**AADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

(Apr. 2003)

**CPT Code:** 36568      **Tracking No:** L10      **Global:** 000      **Recommended RVW:** 1.92

**Descriptor:** Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; under 5 years of age

**SURVEY Vignette (Typical Patient)**

A 3 year-old male requires long-term antimicrobial therapy. A peripherally inserted central venous catheter (PICC) is placed.

**Clinical Description Of Service:**

**Pre-service:** The procedure is explained to the patient's parents and consent obtained. Prior medical records, including any history of prior CV catheter placements/attempts, are reviewed. Arrangements are made with OR/angio suite and anesthesia. Physician assists with patient positioning and scrubs in standard fashion. After gowning, antecubital access site is prepped and draped in usual fashion.

**Intra-service:** Local lidocaine anesthesia is administered. The basilic vein is punctured. The peripherally inserted central venous catheter is cut to length and then placed. The catheter is fastened in position and dressed in standard fashion, and flushed or attached to IV infusion fluids.

**Post service:** Orders are written for IV fluids. Catheter and insertion site wound care is prescribed. A note is placed in the patient chart and report dictated.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	American College of Surgeons; Charles Mabry, MD, FACS American Pediatric Surgical Association; Samuel Smith, MD, FACS Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36568				
<b>Sample Size:</b>	250	<b>Resp n:</b>	32	<b>Resp %:</b>	13%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.64	2.00	2.54	3.08	6.25
<b>Pre-Service Evaluation Time:</b>			20		
<b>Pre-Service Positioning Time:</b>			5		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5		
<b>Intra-Service Time:</b>	15	20	20	30	75
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	10				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	0				
<b>Office time/visit(s):</b>	0				

\*Physician standard total minutes per E/M visit. 99291 (60); 99292 (30); 99233 (41), 99232 (30); 99231 (19); 99238 (36); 99215 (59), 99214 (38); 99213 (23), 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36488	Placement of central venous catheter (subclavian, jugular, or other vein), (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, age 2 years or under	1.35	0

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

	Svy CPT 36568	Ref CPT 36488 hvd
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	32	--
Pre-service	30	9
Intra-service	20	24
Same Day Immediate Post-service	10	9
Critical care	0	0
Other hospital visit	0	0
Discharge day management	0	0
Office visit	0	0
<i>TOTAL TIME</i>	60	42

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	9	9
--------------------------	---	---

**TIME SEGMENTS**

Pre-service	2.25	1.88
Intra-service	3.50	2.13
Post-service	1.88	2.00

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	3.00	1.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.14	1.57
Urgency of medical decision making	1.50	1.57

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	3.00	2.71
Physical effort required	2.63	2.14

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	2.25	2.29
Outcome depends on the skill and judgment of physician	3.00	2.86
Estimated risk of malpractice suit with poor outcome	1.88	3.00

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

**(Apr. 2003)**

**CPT Code:** 36569      **Tracking No:** L11      **Global:** 000      **Recommended RVW:** 1.82

**Descriptor:** Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older

**SURVEY Vignette (Typical Patient)**

A 62 year-old male requires long term antimicrobial therapy. A peripherally inserted central venous catheter (PICC) is inserted.

**Clinical Description Of Service:**

**Pre service:** The procedure is explained to the patient and consent obtained. Prior medical records, including any history of prior CV catheter placements/attempts, are reviewed. The physician gowns and gloves. The access site is prepped and draped in standard fashion.

**Intra service:** Local lidocaine anesthesia is administered. The basilic vein is punctured and a guidewire passed centrally. The peripherally inserted central venous catheter is cut to appropriate length and then placed. The catheter is sutured in position and dressed in standard fashion, and flushed or attached to IV infusion fluids.

**Post service:** Orders are written for IV fluids. Wound site care and catheter management is prescribed. A note is placed in the patient chart and report dictated.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	American College of Surgeons; Charles Mabry, MD, FACS American Pediatric Surgical Association; Samuel Smith, MD, FACS Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36569				
<b>Sample Size:</b>	250	<b>Resp n:</b>	33	<b>Resp %:</b>	13%
<b>Sample Type:</b>					
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.50	2.00	2.50	2.50	3.50
<b>Pre-Service Evaluation Time:</b>			15		
<b>Pre-Service Positioning Time:</b>			5		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5		
<b>Intra-Service Time:</b>	5	15	20	20	60
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	10				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	0				
<b>Office time/visit(s):</b>	0				

\*Physician standard total minutes per E/M visit: 99291 (60), 99292 (30), 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59), 99214 (38); 99213 (23), 99212 (15); 99211 (7)

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36489	Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2	2.50	0

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

	Svy CPT 36569	Ref CPT 36489 2 <sup>nd</sup> 5-YR
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	33	--
Pre-service	25	15
Intra-service	20	20
Same Day Immediate Post-service	10	15
Critical care	0	0
Other hospital visit	0	0
Discharge day management	0	0
Office visit	0	0
<i>TOTAL TIME</i>	55	50

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	22	22
<b>TIME SEGMENTS</b>		
Pre-service	1.58	1.68
Intra-service	2.26	1.74
Post-service	1.63	1.78
<b>MENTAL EFFORT AND JUDGMENT</b>		
The number of possible diagnosis and/or the number of management options that must be considered	2.35	1.68
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.95	1.74
Urgency of medical decision making	1.55	1.72
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>		
Technical skill required	2.15	2.42
Physical effort required	1.75	2.00
<b>PSYCHOLOGICAL STRESS</b>		
The risk of significant complications, morbidity and/or mortality	1.70	2.00
Outcome depends on the skill and judgment of physician	2.30	2.37
Estimated risk of malpractice suit with poor outcome	1.65	2.00

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

(Apr. 2003)

**CPT Code:** 36570      **Tracking No:** L12      **Global:** 010      **Recommended RVW:** 5.32

**Descriptor:** Insertion of peripherally inserted central venous access device with subcutaneous port; under 5 years of age

**SURVEY Vignette (Typical Patient)**

A 4-year-old girl needs long term intravenous therapy. A peripherally inserted central venous access catheter with subcutaneous port is placed.

**Clinical Description Of Service:**

Pre service: The procedure is explained to the patient's parents and consent obtained. Prior medical records, including any history of prior CV catheter placements/attempts, are reviewed. Arrangements are made with OR/angio suite and anesthesia. Physician assists with patient positioning and arm immobilization, and scrubs in standard fashion. After gowning, arm access and pocket site is prepped and draped in usual fashion

Intra service: Local lidocaine anesthesia is administered. The basilic vein is punctured. Peripherally inserted central catheter is measured and cut to length and then placed. A subcutaneous pocket is created. The catheter is attached to the port and connection tested by injection. The port is secured in the pocket. The pocket is sutured and dressed in standard fashion.

Post service: Orders are written for IV fluids, catheter care and port flushing. A note is placed in the patient chart and report dictated. The patient is seen in the office to check the wounds.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	American College of Surgeons; Charles Mabry, MD, FACS American Pediatric Surgical Association; Samuel Smith, MD, FACS Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36570				
<b>Sample Size:</b>	250	<b>Resp n:</b>	23	<b>Resp %:</b>	9%
<b>Sample Type:</b>					
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	2.50	5.32	5.50	6.32	9.00
<b>Pre-Service Evaluation Time:</b>			30		
<b>Pre-Service Positioning Time:</b>			10		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10		
<b>Intra-Service Time:</b>	20	40	45	55	120
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	18	99238 x 0.5			
<b>Office time/visit(s):</b>	15	99212 x 1			

\*Physician standard total minutes per E/M visit. 99291 (60), 99292 (30), 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38), 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36533	Insertion of implantable venous access device, with or without subcutaneous reservoir	5.32	10

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

	Svy CPT 36570	Ref CPT 36533 1 <sup>st</sup> 5-YR
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	23	36
Pre-service	50	30
Intra-service	45	45
Same Day Immediate Post-service	15	20
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	18
Office visit	15	23
<i>TOTAL TIME</i>	<i>143</i>	<i>136</i>

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	16	16
--------------------------	----	----

**TIME SEGMENTS**

Pre-service	2.53	2.53
Intra-service	3.40	2.53
Post-service	2.07	2.13

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	3.20	2.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.53	2.27
Urgency of medical decision making	2.67	2.00

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	3.40	3.33
Physical effort required	2.93	2.60

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	2.53	2.73
Outcome depends on the skill and judgment of physician	3.27	3.07
Estimated risk of malpractice suit with poor outcome	2.20	2.87

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

(Apr. 2003)

**CPT Code:** 36571      **Tracking No:** L13      **Global:** 010      **Recommended RVW:** 5.30

**Descriptor:** Insertion of peripherally inserted central venous access device with subcutaneous port; age 5 years or older

**SURVEY Vignette (Typical Patient)**

A 30 year-old male requires long term intravenous therapy. A peripherally inserted central venous access device with a subcutaneous port is inserted.

**Clinical Description Of Service:**

Pre service: The procedure is explained to the patient and consent obtained. Prior medical records, including any history of prior CV catheter placements/attempts, are reviewed. Physician assists with patient positioning and scrubs in standard fashion. After gowning, access and pocket site is prepped and draped in usual fashion.

Intra service: Local lidocaine anesthesia is administered. The basilic vein is punctured and a guidewire passed centrally. A subcutaneous pocket is then created. The catheter is measured to length and then placed. The catheter is connected to the port device and connection checked with injection. The port is secured into the pocket. The skin incisions are sutured. The wounds are dressed in standard fashion.

Post service: Orders are written for port flushing. Once the catheter position is confirmed, wound care is prescribed. A note is placed in the patient chart and report dictated. The patient is seen in the office to check the wounds.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	American College of Surgeons; Charles Mabry, MD, FACS American Pediatric Surgical Association; Samuel Smith, MD, FACS Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36571				
<b>Sample Size:</b>	250	<b>Resp n:</b>	27	<b>Resp %:</b>	11%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	2.50	5.30	5.50	6.26	8.00
<b>Pre-Service Evaluation Time:</b>			20		
<b>Pre-Service Positioning Time:</b>			10		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10		
<b>Intra-Service Time:</b>	15	38	50	60	90
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	18	99238 x 0.5			
<b>Office time/visit(s):</b>	15	99212 x 1			

\*Physician standard total minutes per E/M visit 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36533	Insertion of implantable venous access device, with or without subcutaneous reservoir	5.32	10

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

	Svy CPT 36571b	Ref CPT 36533 1 <sup>st</sup> 5-YR
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	27	36
Pre-service	40	30
Intra-service	50	45
Same Day Immediate Post-service	15	20
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	18
Office visit	15	23
<i>TOTAL TIME</i>	138	136

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	18	18
--------------------------	----	----

**TIME SEGMENTS**

Pre-service	2.47	2.53
Intra-service	3.29	2.47
Post-service	2.06	2.00

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	3.18	2.47
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.53	2.24
Urgency of medical decision making	2.65	2.06

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	3.24	3.24
Physical effort required	2.65	2.59

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	2.59	2.71
Outcome depends on the skill and judgment of physician	3.24	3.12
Estimated risk of malpractice suit with poor outcome	2.12	2.59

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

(Apr. 2003)

**CPT Code:** 36575      **Tracking No:** L14      **Global:** 000      **Recommended RVW:** 0.67

**Descriptor:** Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site

**SURVEY Vignette (Typical Patient)**

A patient has a previously placed, single lumen central venous catheter without port/pump. In the process of cutting tape for a home dressing change, the patient accidentally cuts the catheter six inches from the skin. He has clamped the cut catheter and presents for catheter repair.

**Clinical Description Of Service:**

Pre service: Physician scrubs in standard fashion. Exposed catheter is prepped in standard fashion.

Intra service: Under usual sterile conditions, the remaining catheter is trimmed perpendicular to the catheter axis. A new catheter hub segment is spliced onto the existing catheter and the splice tested with injection. The catheter is then redressed and flushed in standard fashion.

Post service work: Note is made in the patient chart and report dictated.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36575				
<b>Sample Size:</b>	190	<b>Resp n:</b>	23	<b>Resp %:</b>	12%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.30	1.10	1.75	2.20	3.50
<b>Pre-Service Evaluation Time:</b>			10		
<b>Pre-Service Positioning Time:</b>			0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5		
<b>Intra-Service Time:</b>	5	10	15	20	45
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	9				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	0				
<b>Office time/visit(s):</b>	0				

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41), 99232 (30); 99231 (19), 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15), 99211 (7)

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36534	Revision of implantable venous access device, and/or subcutaneous reservoir	2.80	10

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

	Svy CPT 36575	Ref CPT 36534 hvd
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	23	--
Pre-service	15	16
Intra-service	15	52
Same Day Immediate Post-service	9	30
Critical care	0	0
Other hospital visit	0	0
Discharge day management	0	0
Office visit	0	0
<i>TOTAL TIME</i>	39	98

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	7	7
--------------------------	---	---

**TIME SEGMENTS**

Pre-service	1.71	1.57
Intra-service	2.14	1.14
Post-service	1.57	1.71

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	2.14	1.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.43	1.33
Urgency of medical decision making	1.57	1.83

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	2.00	2.50
Physical effort required	1.43	2.00

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	2.14	2.00
Outcome depends on the skill and judgment of physician	2.71	2.00
Estimated risk of malpractice suit with poor outcome	1.86	1.33

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

(Apr. 2003)

**CPT Code:** 36576      **Tracking No:** L15      **Global:** 010      **Recommended RVW:** 3.19

**Descriptor:** Repair of central venous access device with subcutaneous port or pump, central or peripheral insertion site

**SURVEY Vignette (Typical Patient)**

A patient presents with a radiologically confirmed leak in a previously placed central venous catheter with subcutaneous port or pump immediately adjacent to the catheter connection to the subcutaneous port/pump.

**Clinical Description Of Service:**

Pre service work: Arrangements are made with OR/angio suite. The replacement procedure is explained to the patient or parents and consent obtained. Physician assists with patient positioning, and scrubs in standard fashion. After gowning, the pocket site is prepped and draped in usual fashion

Intra service work: Local lidocaine anesthesia is administered at the site of the existing subcutaneous pocket. Under usual sterile conditions, the port pocket opened. The catheter is disconnected, trimmed proximal to the damaged section, and reconnected to the port/pump. The connection is tested by injection. The port/pump is resecured in the pocket and the pocket is sutured closed. The wound is dressed in standard fashion.

Post service: Wound care is prescribed. Orders are written for port flushing. Note is made in the patient chart and report dictated. The patient is seen in the office to check the wound.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36576				
<b>Sample Size:</b>	190	<b>Resp n:</b>	16	<b>Resp %:</b>	8%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	2.80	2.95	3.35	5.55	7.00
<b>Pre-Service Evaluation Time:</b>			25		
<b>Pre-Service Positioning Time:</b>			6		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10		
<b>Intra-Service Time:</b>	20	29	33	49	90
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	18	99238 x 0.5			
<b>Office time/visit(s):</b>	15	99212 x 1			

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30), 99233 (41); 99232 (30), 99231 (19), 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36534	Revision of implantable venous access device, and/or subcutaneous reservoir	2 80	10

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

	Svy CPT 36576	Ref CPT 35634 hvd
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	16	--
Pre-service	40	16
Intra-service	33	52
Same Day Immediate Post-service	10	30
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	0
Office visit	15	0
<i>TOTAL TIME</i>	116	98

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	13	13
--------------------------	----	----

**TIME SEGMENTS**

Pre-service	2.00	2.25
Intra-service	2.67	2.00
Post-service	1.50	1.92

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	3.17	2.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.25	2.00
Urgency of medical decision making	2.42	1.92

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	2.92	3.00
Physical effort required	2.50	2.33

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	2.08	2.33
Outcome depends on the skill and judgment of physician	2.75	2.75
Estimated risk of malpractice suit with poor outcome	1.83	2.33

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

(Apr. 2003)

**CPT Code:** 36578      **Tracking No:** L16      **Global:** 010      **Recommended RVW:** 3.50

**Descriptor:** Replacement. catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site

**SURVEY Vignette (Typical Patient)**

A patient presents with a double lumen tunneled central venous catheter (one catheter with two lumens through one venous entry site) with subcutaneous port. The port cannot be aspirated but recent CXR demonstrated the catheter tip to be in good position. Only the catheter requires replacement.

**Clinical Description Of Service:**

**Pre-service:** The procedure is explained to the patient or parents and consent obtained. Arrangements are made with OR/angio suite. Physician assists with patient positioning and scrubs in standard fashion. After gowning, port site is prepped and draped in usual fashion.

**Intra service:** Local lidocaine anesthesia is administered at the site of the existing subcutaneous pocket. The pocket is incised and the port dissected free. The port is examined and found to be functioning. The catheter channels are found to be occluded. A guidewire is able to be advanced through one of the channels and the old catheter withdrawn. A new dual channel catheter is cut to length and advanced over the guidewire into central venous position. The catheter is connected to the port device and connections checked with injection. The port is secured in the chest wall pocket. The skin incision is sutured and the wound dressed in standard fashion.

**Post service:** Orders are written for port flushing and portable CXR. Catheter position is confirmed and no pneumothorax is detected. Wound care is prescribed. A note is placed in the patient chart and report dictated. The patient is seen in the office to check the wound.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36578				
<b>Sample Size:</b>	190	<b>Resp n:</b>	14	<b>Resp %:</b>	7%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	2.75	3.09	4.50	5.50	7.00
<b>Pre-Service Evaluation Time:</b>			20		
<b>Pre-Service Positioning Time:</b>			6		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10		
<b>Intra-Service Time:</b>	15	30	30	44	90
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	18	99238 x 0.5			
<b>Office time/visit(s):</b>	15	99212 x 1			

\*Physician standard total minutes per E/M visit: 99291 (60), 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36), 99215 (59); 99214 (38), 99213 (23), 99212 (15), 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36534	Revision of implantable venous access device, and/or subcutaneous reservoir	2.80	10

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

	Svy CPT 36578	Ref CPT 36534 hvd
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	14	--
Pre-service	36	16
Intra-service	30	52
Same Day Immediate Post-service	12	30
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	0
Office visit	15	0
<b>TOTAL TIME</b>	<b>111</b>	<b>98</b>

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	10	10
--------------------------	----	----

**TIME SEGMENTS**

Pre-service	1.75	2.44
Intra-service	2.25	2.11
Post-service	1.50	1.78

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	2.78	2.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	2.00
Urgency of medical decision making	2.11	1.89

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	2.67	2.78
Physical effort required	2.44	2.00

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	1.88	2.22
Outcome depends on the skill and judgment of physician	2.13	2.56
Estimated risk of malpractice suit with poor outcome	1.63	2.33

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

**(Apr. 2003)**

**CPT Code:** 36580      **Tracking No:** L17      **Global:** 000      **Recommended RVW:** 1.31

**Descriptor:** Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access

**SURVEY Vignette (Typical Patient)**

A patient with a non-tunneled central venous catheter is referred due to poor flow rates despite prior attempts at removal of pericatheter and intracatheter material. Decision is made to replace the existing catheter through the same venous entry site.

**Clinical Description Of Service:**

Pre service: The procedure is explained to the patient or parents and consent obtained. Prior medical records, including radiographs of the current catheter position, are reviewed. Arrangements made with the nursing staff, OR or angio suite. The physician gowns and gloves. The existing catheter and access site are prepped and draped in standard fashion.

Intra service: Local lidocaine anesthesia is administered. A guidewire is passed centrally through the existing catheter. The existing catheter is removed and a new CV catheter is then placed. The catheter is sutured in position and dressed in standard fashion, and flushed or attached to IV infusion fluids.

Post service: Orders are written for IV fluids or catheter and entry site care as well as for portable CXR. Catheter position is confirmed and no pneumothorax is detected. A note is placed in the patient chart and report dictated.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	American College of Surgeons; Charles Mabry, MD, FACS American Pediatric Surgical Association; Samuel Smith, MD, FACS Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36580				
<b>Sample Size:</b>	250	<b>Resp n:</b>	40	<b>Resp %:</b>	16%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	1.50	2.00	2.50	4.00
<b>Pre-Service Evaluation Time:</b>			15		
<b>Pre-Service Positioning Time:</b>			5		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5		
<b>Intra-Service Time:</b>	5	11	15	20	45
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	10				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	0				
<b>Office time/visit(s):</b>	0				

\*Physician standard total minutes per E/M visit: 99291 (60), 99292 (30), 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59), 99214 (38); 99213 (23); 99212 (15); 99211 (7)

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36489	Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy), percutaneous, over age 2	2.50	0

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

	Svy CPT 36580	Ref CPT 36489 2 <sup>nd</sup> 5-YR
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	40	--
Pre-service	25	15
Intra-service	15	20
Same Day Immediate Post-service	10	15
Critical care	0	0
Other hospital visit	0	0
Discharge day management	0	0
Office visit	0	0
<i>TOTAL TIME</i>	50	50

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	24	24
--------------------------	----	----

**TIME SEGMENTS**

Pre-service	1.65	2.00
Intra-service	1.95	2.10
Post-service	1.60	2.15

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	1.68	1.91
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.77	2.00
Urgency of medical decision making	1.64	2.14

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	2.05	2.45
Physical effort required	1.71	2.14

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	1.91	2.23
Outcome depends on the skill and judgment of physician	2.14	2.45
Estimated risk of malpractice suit with poor outcome	1.73	2.05

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

**(Apr. 2003)**

**CPT Code:** 36581      **Tracking No:** L18      **Global:** 010      **Recommended RVW:** 3.44

**Descriptor:** Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access

**SURVEY Vignette (Typical Patient)**

A patient with a tunneled central venous catheter without port/pump is referred due to poor flow rates despite prior attempts at removal of pericatheter and intracatheter material. Decision is made to replace the existing catheter through the same venous entry site.

**Clinical Description Of Service:**

Pre service: The procedure is explained to the patient or parents and consent obtained. Prior medical records, including radiographs of the current catheter position, are reviewed. Arrangements made with the nursing staff, OR or angio suite. The physician gowns and gloves. The existing catheter and access site are prepped and draped in standard fashion.

Intra service: Local lidocaine anesthesia is administered. The cuff of the indwelling tunneled catheter is dissected free from the subcutaneous tissue. A guidewire is passed centrally through the existing catheter. The existing catheter is removed and a new CV catheter is then placed. The catheter is sutured in position and dressed in standard fashion, and flushed or attached to IV infusion fluids.

Post service: Orders are written for catheter care and wound care. Catheter position is confirmed and no pneumothorax is detected. A note is placed in the patient chart and report dictated. The patient is seen in the office to check the wound.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36581				
<b>Sample Size:</b>	190	<b>Resp n:</b>	17	<b>Resp %:</b>	9%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.50	2.80	3.00	3.50	5.50
<b>Pre-Service Evaluation Time:</b>			20		
<b>Pre-Service Positioning Time:</b>			5		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10		
<b>Intra-Service Time:</b>	10	20	30	40	60
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	18	99238 x 0.5			
<b>Office time/visit(s):</b>	15	99212 x 1			

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36534	Revision of implantable venous access device, and/or subcutaneous reservoir	2.80	10

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

	Svy CPT 36581	Ref CPT 36534 hvd
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	17	--
Pre-service	35	16
Intra-service	30	52
Same Day Immediate Post-service	10	30
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	0
Office visit	15	0
<i>TOTAL TIME</i>	<i>108</i>	<i>98</i>

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	13	13
--------------------------	----	----

**TIME SEGMENTS**

Pre-service	1.78	2.36
Intra-service	2.33	2.18
Post-service	1.67	2.09

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	2.91	2.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.18	2.09
Urgency of medical decision making	2.36	2.09

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	2.82	2.91
Physical effort required	2.55	2.18

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	1.89	2.45
Outcome depends on the skill and judgment of physician	2.22	2.73
Estimated risk of malpractice suit with poor outcome	1.78	2.55

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

(Apr. 2003)

**CPT Code:** 36582      **Tracking No:** L19      **Global:** 010      **Recommended RVW:** 5.20

**Descriptor:** Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous port, through same venous access

**SURVEY Vignette (Typical Patient)**

A patient presents with a double lumen tunneled central venous catheter (one catheter with two lumens through one venous entry site) with subcutaneous ports. The ports cannot be aspirated but recent CXR demonstrated the catheter tip to be in good position.

**Clinical Description Of Service:**

**Pre service:** The procedure is explained to the patient or parents and consent obtained. Prior medical records, including radiographs of the current catheter position, are reviewed. Arrangements made with the nursing staff, OR or angio suite. The physician gowns and gloves. The existing port site is prepped and draped in standard fashion.

**Intra service:** Local lidocaine anesthesia is administered. The subcutaneous pocket is surgically incised and the port dissected free. The catheter is disconnected from the port and the port removed. A guidewire is passed centrally through the existing catheter. The existing catheter is removed and a new CV catheter is measured to correct length and then placed. The catheter is connected to the new port device and connections checked with injection. The port is secured into the chest wall pocket. The skin incision is sutured. The wound is dressed in standard fashion.

**Post service:** Orders are written for port flushing, wound care and portable CXR. Catheter position is confirmed and no pneumothorax is detected. A note is placed in the patient chart and report dictated. The patient is seen in the office to check the wound.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36582				
<b>Sample Size:</b>	190	<b>Resp n:</b>	14	<b>Resp %:</b>	7%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	3.38	4.25	5.73	6.24	8.00
<b>Pre-Service Evaluation Time:</b>			30		
<b>Pre-Service Positioning Time:</b>			6		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10		
<b>Intra-Service Time:</b>	15	36	60	60	120
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	18	99238 x 0.5			
<b>Office time/visit(s):</b>	15	99212 x 1			

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19), 99238 (36), 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36534	Revision of implantable venous access device, and/or subcutaneous reservoir	2 80	10

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

	Svy CPT 36582	Ref CPT 36534 hvd
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	14	--
Pre-service	46	16
Intra-service	60	52
Same Day Immediate Post-service	12	30
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	0
Office visit	15	0
<i>TOTAL TIME</i>	<i>151</i>	<i>98</i>

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	8	8
--------------------------	---	---

**TIME SEGMENTS**

Pre-service	1.71	2.57
Intra-service	2.71	2.14
Post-service	1.71	1.86

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	2.71	2.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.14	2.00
Urgency of medical decision making	2.14	1.86

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	3.00	2.57
Physical effort required	2.57	2.00

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	1.86	2.29
Outcome depends on the skill and judgment of physician	2.14	2.71
Estimated risk of malpractice suit with poor outcome	1.71	2.57

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

(Apr. 2003)

**CPT Code:** 36583      **Tracking No:** L20      **Global:** 010      **Recommended RVW:** 5.25

**Descriptor:** Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous pump, through same venous access

**SURVEY Vignette (Typical Patient)**

A 50-year-old male with an existing central venous catheter with subcutaneous pump is referred due to pump malfunction. Decision is made to replace the pump and central venous catheter through the same venous access site.

**Clinical Description Of Service:**

**Pre service:** The procedure is explained to the patient and consent obtained. Prior medical records, including radiographs of the current catheter position, are reviewed. Arrangements made with the OR or angio suite. The physician gowns and gloves. The existing subcutaneous pump site is prepped and draped in standard fashion.

**Intra service:** Local lidocaine anesthesia is administered. The subcutaneous pocket is surgically incised and the pump dissected free. The pump is tested and found to be non-functional. The catheter is disconnected from the pump and the pump removed. A guidewire is passed centrally through the existing catheter. The existing catheter is removed and a new CV catheter is measured to correct length and then placed. The catheter is connected to a new pump device and connection checked with injection. The pump is secured in the chest wall pocket. The skin incision is sutured. The wound is dressed in standard fashion.

**Post service:** Orders are written for wound care and portable CXR. Catheter position is confirmed and no pneumothorax is detected. A note is placed in the patient chart and report dictated. The patient is seen in the office to check the wound.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36583				
<b>Sample Size:</b>	190	<b>Resp n:</b>	13	<b>Resp %:</b>	7%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	3.38	4.00	6.00	6.50	7.00
<b>Pre-Service Evaluation Time:</b>			30		
<b>Pre-Service Positioning Time:</b>			7		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10		
<b>Intra-Service Time:</b>	30	55	60	70	120
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	18	99238 x 0.5			
<b>Office time/visit(s):</b>	15	99212 x 1			

\*Physician standard total minutes per E/M visit. 99291 (60), 99292 (30), 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7)

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36534	Revision of implantable venous access device, and/or subcutaneous reservoir	2 80	10

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

<b>TIME ESTIMATES (MEDIAN)</b>	<b>Svy CPT 36583</b>	<b>Ref CPT 36534</b>
Survey Response count	13	--
Pre-service	47	16
Intra-service	60	52
Same Day Immediate Post-service	13	30
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	0
Office visit	15	0
<i>TOTAL TIME</i>	153	98

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	7	7
--------------------------	---	---

**TIME SEGMENTS**

Pre-service	1.83	2.83
Intra-service	2.83	2.17
Post-service	1.83	2.00

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.17	2.17
Urgency of medical decision making	2.33	2.00

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	3.17	2.67
Physical effort required	2.67	2.00

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	1.83	2.33
Outcome depends on the skill and judgment of physician	2.17	2.83
Estimated risk of malpractice suit with poor outcome	1.67	2.67

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

(Apr. 2003)

**CPT Code:** 36584      **Tracking No:** L21      **Global:** 000      **Recommended RVW:** 1.20

**Descriptor:** Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access

**SURVEY Vignette (Typical Patient)**

A patient is referred due to occlusion of the previously placed PICC line.

**Clinical Description Of Service:**

Pre-service: The procedure is explained to the patient or parents and consent obtained. Prior medical records, including radiographs documenting current catheter position and any history of prior CV catheter placements/attempts, are reviewed. Arrangements are made with nursing staff, OR or angio suite. Physician assists with patient positioning and scrubs in standard fashion. After gowning, the existing catheter access site is prepped and draped in usual fashion.

Intra-service: Local lidocaine anesthesia is administered. The existing catheter is cut and partially withdrawn. A vascular sheath is placed over the occluded catheter into the access vein and the old catheter removed. A guidewire is advanced through the new sheath centrally. The new catheter is then cut to appropriate length and advanced over the guidewire through the sheath. The sheath is removed. The catheter is fastened in position and dressed and flushed in standard fashion.

Post service: Orders are written for entry site care and catheter flushing. A note is placed in the patient chart and report dictated.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36584				
<b>Sample Size:</b>	190	<b>Resp n:</b>	24	<b>Resp %:</b>	13%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	1.50	2.00	2.03	2.80
<b>Pre-Service Evaluation Time:</b>			15		
<b>Pre-Service Positioning Time:</b>			0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			5		
<b>Intra-Service Time:</b>	8	10	15	20	45
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	10				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	0				
<b>Office time/visit(s):</b>	0				

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19), 99238 (36); 99215 (59), 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36489	Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2	2.50	0

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

	Svy CPT 36584	Ref CPT 36489 2 <sup>nd</sup> 5YR
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	24	--
Pre-service	20	15
Intra-service	15	20
Same Day Immediate Post-service	10	15
Critical care	0	0
Other hospital visit	0	0
Discharge day management	0	0
Office visit	0	0
<i>TOTAL TIME</i>	45	50

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	12	12
--------------------------	----	----

**TIME SEGMENTS**

Pre-service	1.50	1.58
Intra-service	1.92	1.42
Post-service	1.50	1.92

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	1.67	1.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.75	1.83
Urgency of medical decision making	1.58	2.17

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	1.83	2.33
Physical effort required	1.45	1.92

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	1.75	2.00
Outcome depends on the skill and judgment of physician	2.33	2.25
Estimated risk of malpractice suit with poor outcome	1.75	1.75

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION

(Apr. 2003)

**CPT Code:** 36585      **Tracking No:** L22      **Global:** 010      **Recommended RVW:** 4.80

**Descriptor:** Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access

**SURVEY Vignette (Typical Patient)**

A patient presents with a previously placed peripherally inserted central venous access device with a subcutaneous port that is occluded and not functional. Decision is made to replace the port and catheter from the same venous access site.

**Clinical Description Of Service:**

**Pre service:** The procedure is explained to the patient or parents and consent obtained. Prior medical records, including radiographs documenting current catheter position and any history of prior CV catheter placements/attempts, are reviewed. Physician assists with patient positioning and scrubs in standard fashion. After gowning, port site is prepped and draped in usual fashion.

**Intra service:** Local lidocaine anesthesia is administered. The skin is surgically incised and the existing port dissected free. The port is disconnected from the catheter and found to be non-functional. A guidewire is advanced centrally through the existing catheter. The new catheter is then cut to length and advanced over the guidewire. The new catheter is connected to the new port device and connection checked with injection. The port is placed into the pocket and secured. The skin incision is sutured. The wounds are dressed in standard fashion.

**Post service:** Orders are written for port flushing and CXR if indicated. The catheter position is confirmed. Wound care is prescribed. A note is placed in the patient chart and report dictated. The patient is seen in the office to check the wound.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36585				
<b>Sample Size:</b>	190	<b>Resp n:</b>	14	<b>Resp %:</b>	7%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	3.38	4.00	5.75	6.32	8.00
<b>Pre-Service Evaluation Time:</b>			6		
<b>Pre-Service Positioning Time:</b>			10		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10		
<b>Intra-Service Time:</b>	30	30	60	70	120
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	18	99238 x 0.5			
<b>Office time/visit(s):</b>	15	99212 x 1			

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36), 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36534	Revision of implantable venous access device, and/or subcutaneous reservoir	2.80	10

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

	Svy CPT 36585	Ref CPT 36534 hvd
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	14	--
Pre-service	26	16
Intra-service	60	52
Same Day Immediate Post-service	13	30
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	0
Office visit	15	0
<i>TOTAL TIME</i>	132	98

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	8	8
--------------------------	---	---

**TIME SEGMENTS**

Pre-service	1.71	2.57
Intra-service	2.43	2.14
Post-service	1.71	1.86

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	2.71	2.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	2.00
Urgency of medical decision making	2.29	2.00

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	3.14	2.71
Physical effort required	2.71	2.14

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	1.86	2.29
Outcome depends on the skill and judgment of physician	2.14	2.71
Estimated risk of malpractice suit with poor outcome	1.71	2.57

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

(Apr. 2003)

**CPT Code:** 36589      **Tracking No:** L23      **Global:** 010      **Recommended RVW:** 2.27

**Descriptor:** Removal of tunneled central venous catheter, without subcutaneous port or pump

**SURVEY Vignette (Typical Patient)**

A patient with a previously placed tunneled central venous dialysis catheter no longer needs central venous access. Discussion with the patient and physician confirms the decision to remove the previously placed catheter.

**Clinical Description Of Service:**

**Pre-service:** The procedure is explained to the patient or parents and consent obtained. The catheter site is prepped and draped.

**Intra-service:** Local lidocaine anesthesia is injected. The tunneled central venous catheter is surgically removed by cut-down and blunt dissection. Hemostasis is established with manual pressure. The wound is closed and dressed in standard fashion.

**Post service:** Wound care is prescribed. The patient is seen in the office for post catheter removal for wound check.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	American College of Surgeons; Charles Mabry, MD, FACS American Pediatric Surgical Association; Samuel Smuth, MD, FACS Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36589				
<b>Sample Size:</b>	250	<b>Resp n:</b>	34	<b>Resp %:</b>	14%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	1.63	2.27	2.30	5.50
<b>Pre-Service Evaluation Time:</b>			12		
<b>Pre-Service Positioning Time:</b>			5		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			8		
<b>Intra-Service Time:</b>	4	10	13	20	45
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	18	99238 x 0.5			
<b>Office time/visit(s):</b>	7	99211 x 1			

\*Physician standard total minutes per E/M visit: 99291 (60), 99292 (30), 99233 (41); 99232 (30), 99231 (19); 99238 (36), 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36535	Removal of implantable venous access device, and/or subcutaneous reservoir	2.27	10

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

	Svy CPT 36589	Ref CPT 36535 hvd
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	34	--
Pre-service	25	16
Intra-service	13	27
Same Day Immediate Post-service	10	30
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	0
Office visit	7	0
<i>TOTAL TIME</i>	73	73

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	27	27
--------------------------	----	----

**TIME SEGMENTS**

Pre-service	1.50	1.67
Intra-service	1.96	1.71
Post-service	1.46	1.67

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	1.80	1.72
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.72	1.72
Urgency of medical decision making	1.72	1.72

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	1.92	2.20
Physical effort required	1.88	1.96

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	1.56	2.00
Outcome depends on the skill and judgment of physician	2.08	2.12
Estimated risk of malpractice suit with poor outcome	1.56	2.00

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

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

(Apr. 2003)

**CPT Code:** 36590      **Tracking No:** L24      **Global:** 010      **Recommended RVW:** 3.30

**Descriptor:** Removal of tunneled central venous access device with subcutaneous port or pump, central or peripheral insertion

**SURVEY Vignette (Typical Patient)**

A patient has completed treatment and no longer needs the previously placed central venous access device with port/pump. Discussion with the patient and their primary physician confirms the decision to remove the previously placed tunneled central venous catheter and port/pump device.

**Clinical Description Of Service:**

**Pre-service:** The procedure is explained to the patient or parents and consent obtained. The port site is prepped and draped in usual fashion.

**Intra-service work:** Local lidocaine anesthesia is administered. The skin is surgically incised and the existing port dissected free. The port and catheter are removed. Hemostasis is established with manual pressure. The port pocket is closed and dressed in standard fashion.

**Post service:** Wound care is prescribed and post-operative care is provided. The patient is seen in the office for a wound check and suture removal.

**SURVEY DATA**

<b>Presenter(s):</b>	American College of Radiology; Bibb Allen, Jr, MD				
<b>Specialty(s):</b>	American College of Surgeons; Charles Mabry, MD, FACS American Pediatric Surgical Association; Samuel Smith, MD, FACS Society of Interventional Radiology; Robert Vogelzang, MD, Zachary Rattner, MD				
<b>CPT Code:</b>	36590				
<b>Sample Size:</b>	250	<b>Resp n:</b>	33	<b>Resp %:</b>	13%
<b>Sample Type:</b>	random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.50	2.27	2.80	3.75	5.70
<b>Pre-Service Evaluation Time:</b>			15		
<b>Pre-Service Positioning Time:</b>			5		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			10		
<b>Intra-Service Time:</b>	10	20	30	35	60
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	18	99238 x 0.5			
<b>Office time/visit(s):</b>	15	99212 x 1			

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38), 99213 (23), 99212 (15), 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
36535	Removal of implantable venous access device, and/or subcutaneous reservoir	2 27	10

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

	Svy CPT 36590	Ref CPT 36535 hvd
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response count	33	--
Pre-service	29	16
Intra-service	30	27
Same Day Immediate Post-service	15	30
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	0
Office visit	15	0
<i>TOTAL TIME</i>	107	73

**INTENSITY/COMPLEXITY MEASURES (mean)**

Reference Response count	26	26
--------------------------	----	----

**TIME SEGMENTS**

Pre-service	1.61	1.74
Intra-service	2.30	1.87
Post-service	1.65	1.78

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	2.21	1.79
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.88	1.79
Urgency of medical decision making	1.96	1.79

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	2.33	2.46
Physical effort required	2.21	2.13

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	1.63	2.04
Outcome depends on the skill and judgment of physician	2.21	2.21
Estimated risk of malpractice suit with poor outcome	1.63	1.96

---

**ADDITIONAL RATIONALE** - See Attachments B and C

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES** - To be provided under separate cover.

**FREQUENCY INFORMATION** - See Attachment D (Worksheet to be completed at RUC meeting)

---

CPT Code: 36597

Tracking No: L29 Global: 000

Recommended RVW: 1.21

**Descriptor:** Repositioning of previously placed central venous catheter under fluoroscopic guidance  
(For fluoroscopic guidance use 76000)

---

### Clinical Description of Service

#### Vignette Used in Survey (typical patient):

The patient is a 60 year old male with congestive heart failure who had a single lumen left subclavian central venous catheter placed for central pressure monitoring. Chest radiograph following insertion of the catheter showed the misposition of the catheter tip in the right internal jugular vein. Repositioning of the central venous catheter to the superior vena cava with fluoroscopic guidance was requested.

**Note:** Do not include the work of imaging in the valuation of this code. The imaging guidance, supervision and interpretation for this procedure is reported separately using 76000.

**Percentage of Survey Respondents who found Vignette to be Typical: 90%**

#### Description of Pre-Service Work:

- Confirm order and discuss with referring physician or clinical staff
- Review chart and prior imaging studies
- Discuss procedure with patient and obtain consent

#### Description of Intra-Service Work:

- Evaluate position of catheter
- Manipulate and reposition catheter to desired location
- Secure catheter to the skin
- Dictate report for medical record

#### Description of Post-Service Work:

- Review and sign report
- Discuss outcome with patient, family and referring physician

**SURVEY DATA**

<b>Presenter(s):</b>	Bibb Allen, Jr., M.D. (ACR) and Zachary Rattner, M.D. (alternate, SIR)				
<b>Specialty(s):</b>	American College of Radiology (ACR), Society of Interventional Radiology (SIR)				
<b>CPT Code:</b>	36597				
<b>Sample Size:</b>	190	<b>Resp n:</b>	21	<b>Resp %:</b>	11%
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.75	1.50	2.00	2.25	3.60
<b>Pre-Service Time:</b>			15.00		
<b>Pre-Service Evaluation Time:</b>					
<b>Pre-Service Positioning Time:</b>					
<b>Pre-Service Scrub, Dress, Wait Time:</b>					
<b>Intra-Service Time:</b>	5.00	15.00	20.00	20.00	45.00
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	10.00				
<b>Critical Care time/visit(s):</b>					
<b>Other Hospital time/visit(s):</b>					
<b>Discharge Day Mgmt:</b>					
<b>Office time/visit(s):</b>					

\*Physician standard total minutes per E/M visit 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19), 99238 (36); 99215 (59); 99214 (38), 99213 (23); 99212 (15), 99211 (7)

**KEY REFERENCE SERVICE:**

CPT	Descriptor	2003 RVW	Global
36489	Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2	2.50	000

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE:**

<b>TIME ESTIMATES (MEDIAN)</b>	Svy CPT 36597	Ref 36489
Pre-service	15.00	15.00
Intra-service	20.00	20.00
Same Day Immediate Post-service	10.00	15.00
Critical care		
Other hospital visit		
Discharge day management		
Office visit		
<b>TOTAL TIME</b>	45.00	50.00 (RUC)
<b>INTENSITY/COMPLEXITY MEASURES (mean)</b>		
<b>Survey Count</b>		9
<b>TIME SEGMENTS</b>		
Pre-service	1.25	1.88
Intra-service	1.88	1.75
Post-service	1.50	1.88
<b>MENTAL EFFORT AND JUDGMENT</b>		
The number of possible diagnosis and/or the number of management options that must be considered	2.25	1.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.88	1.88
Urgency of medical decision making	1.63	2.00
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>		
Technical skill required	1.88	1.57
Physical effort required	2.25	1.88
<b>PSYCHOLOGICAL STRESS</b>		
The risk of significant complications, morbidity and/or mortality	1.63	2.00
Outcome depends on the skill and judgment of physician	2.25	2.13
Estimated risk of malpractice suit with poor outcome	1.63	1.88

**ADDITIONAL RATIONALE**

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

A consensus panel of the American College of Radiology (ACR) and Society of Interventional Radiology (SIR) consisted of physicians who reviewed the survey results. This code is currently valued at 1.21 RVW was surveyed at the request of CMS to establish appropriate rank order within the new CVA family of codes. The 25%tile value from the survey is supported by the survey data and fits in the rank order of the new codes.

**Services Reported with Multiple CPT Codes**

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

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

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

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

CPT Code	Descriptor	Global Period	Pre-Service Time	Intra-Service Time	Post-Service Time	Total Time	RVW
36597	Repositioning of previously placed central venous catheter under fluoroscopic guidance	000	15.00	20.00	10.00	45.00	1.50
76000	Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)					5.00 (Harvard)	0.17



CPT Code: 75998

Tracking No: L27 Global: ZZZ

Recommended RVW: 0.38

**Descriptor:** Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position)

(Do not use 76003 with 75998)

(If formal extremity venography performed from separate venous access and separately interpreted, use 36005 and 75820, 75822, 75825 or 75827)

(List separately in addition to code for primary procedure)

---

### Clinical Description of Service

#### Vignette Used in Survey (typical patient):

Patient is referred for placement of a tunneled central venous catheter. To facilitate advancement of catheter and ensure accurate placement, fluoroscopy is used.

**Percentage of Survey Respondents who found Vignette to be Typical: 100%**

#### Description of Pre-Service Work:

#### Description of Intra-Service Work:

Following achievement of venous access (if fluoroscopic guidance is used for venous access, this is included), fluoroscopy is used to guide the guidewire and subsequently catheter into central venous position. Any contrast injection through access site (via needle, catheter or sheath) for venographic evaluation and mapping of appropriate path is included. Spot film or other radiographic confirmation of final catheter position is performed. Description of all aspects of fluoroscopic guidance are reported with procedure.

#### Description of Post-Service Work

- Review and sign report
- Communicate results to referring physician when appropriate

**SURVEY DATA**

<b>Presenter(s):</b>		Bibb Allen, Jr., M.D. (ACR) and Zachary Rattner, M.D. (alternate, SIR)				
<b>Specialty(s):</b>		American College of Radiology (ACR), Society of Interventional Radiology (SIR)				
<b>CPT Code:</b>		75998				
<b>Sample Size:</b>	190	<b>Resp n:</b>	20	<b>Resp %:</b>	11%	
<b>Sample Type:</b> Random						
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		0.25	0.50	<b>0.70</b>	1.04	1.50
<b>Pre-Service Time:</b>						
<b>Pre-Service Evaluation Time:</b>						
<b>Pre-Service Positioning Time:</b>						
<b>Pre-Service Scrub, Dress, Wait Time:</b>						
<b>Intra-Service Time:</b>		1.00	5.00	<b>9.00</b>	15.00	60.00
<b>Post-Service</b>		<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>		<b>4.00</b>				
<b>Critical Care time/visit(s):</b>						
<b>Other Hospital time/visit(s):</b>						
<b>Discharge Day Mgmt:</b>						
<b>Office time/visit(s):</b>						

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41), 99232 (30); 99231 (19); 99238 (36), 99215 (59); 99214 (38); 99213 (23); 99212 (15), 99211 (7).

**KEY REFERENCE SERVICE:**

CPT	Descriptor	2003 RVW	Glob
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	XXX	0.67

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE:**

<b>TIME ESTIMATES (MEDIAN)</b>	Svy CPT 75998	Ref CPT 76942
Pre-service		
Intra-service	9.00	
Same Day Immediate Post-service	4.00	
Critical care		
Other hospital visit		
Discharge day management		
Office visit		
<b>TOTAL TIME</b>	13.00	23.00 (Harvard)

**INTENSITY/COMPLEXITY MEASURES (mean)**

<b>Survey Count</b>		4
---------------------	--	---

**TIME SEGMENTS**

Pre-service	1.67	2.67
Intra-service	2.00	1.67
Post-service	2.00	1.00

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	2.33	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.00	2.00
Urgency of medical decision making	2.33	1.33

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	3.33	2.33
Physical effort required	2.33	2.00

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	2.00	2.33
Outcome depends on the skill and judgment of physician	2.00	3.33
Estimated risk of malpractice suit with poor outcome	2.00	2.33

**ADDITIONAL RATIONALE**

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

A consensus panel of the American College of Radiology (ACR) and Society of Interventional Radiology (SIR) consisted of physicians who reviewed the survey results and believe that the median value overestimates physician work for fluoroscopic guidance. We believe that the guidance for percutaneous nephrostomy, 74475 (introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation), is an analogous fluoroscopic guidance code. The value of this code is 0.54 RVW and has more time and intensity than guidance for CVL insertion. We believe that 70% of the work value of this code accurately reflects the physician work for 75998 and is the basis of our recommendation of 0.38 RVW.



CPT Code: 76937

Tracking No: L28 Global: ZZZ

Recommended RVW: 0.30

**Descriptor:** Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry, with permanent recording and reporting

(If extremity venous non-invasive vascular diagnostic study is performed separate from venous access guidance, use 93965, 93970 or 93971)

(List separately in addition to code for primary procedure)

---

### Clinical Description of Service

#### Vignette Used in Survey (typical patient):

A patient requires internal jugular central venous catheter placement. The physician decides that ultrasound guidance is necessary for safe IJ venous access.

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

#### Description of Pre-Service Work:

##### Description of Intra-Service Work:

Potential access sites are examined with ultrasound and an acceptable patent access site selected. Permanent documentation of sites examined is recorded. After sterile field has been established, the ultrasound probe is covered with sterile sleeve. Aquasonic gel is applied and real-time ultrasound is performed monitoring the advancement of the access needle into the lumen of the selected vessel. This position is also recorded. Description of the guidance process is included in the final procedure report.

#### Description of Post-Service Work

- Review and sign report of guidance
- Communicate results to referring physician when appropriate

**SURVEY DATA**

<b>Presenter(s):</b>		Bibb Allen, Jr., M.D. (ACR) and Zachary Rattner, M.D. (alternate, SIR)				
<b>Specialty(s):</b>		American College of Radiology (ACR), Society of Interventional Radiology (SIR)				
<b>CPT Code:</b>		76937				
<b>Sample Size:</b>	190	<b>Resp n:</b>	19	<b>Resp %:</b>	10%	
<b>Sample Type:</b> Random						
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		0.50	0.67	<b>0.70</b>	0.88	2.00
<b>Pre-Service Time:</b>						
<b>Pre-Service Evaluation Time:</b>						
<b>Pre-Service Positioning Time:</b>						
<b>Pre-Service Scrub, Dress, Wait Time:</b>						
<b>Intra-Service Time:</b>		3.00	5.00	<b>10.00</b>	18.00	30.00
<b>Post-Service</b>		<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>		<b>4.00</b>				
<b>Critical Care time/visit(s):</b>						
<b>Other Hospital time/visit(s):</b>						
<b>Discharge Day Mgmt:</b>						
<b>Office time/visit(s):</b>						

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30), 99231 (19), 99238 (36); 99215 (59); 99214 (38), 99213 (23); 99212 (15), 99211 (7).

**KEY REFERENCE SERVICE:**

CPT	Descriptor	2003 RVW	Glob
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	XXX	0.67

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE:**

<b>TIME ESTIMATES (MEDIAN)</b>	Svy CPT 76937	Ref CPT 76942
Pre-service		
Intra-service	10.00	30.00
Same Day Immediate Post-service	4.00	
Critical care		
Other hospital visit		
Discharge day management		
Office visit		
<b>TOTAL TIME</b>	14.00	30.00 (RUC)
<b>INTENSITY/COMPLEXITY MEASURES (mean)</b>		
Survey Count		15
<b>TIME SEGMENTS</b>		
Pre-service	1.36	1.93
Intra-service	2.29	1.64
Post-service	1.36	1.93
<b>MENTAL EFFORT AND JUDGMENT</b>		
The number of possible diagnosis and/or the number of management options that must be considered	2.57	1.93
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.86	1.64
Urgency of medical decision making	2.00	1.93
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>		
Technical skill required	2.79	2.57
Physical effort required	1.86	1.86
<b>PSYCHOLOGICAL STRESS</b>		
The risk of significant complications, morbidity and/or mortality	1.57	2.14
Outcome depends on the skill and judgment of physician	2.36	2.86
Estimated risk of malpractice suit with poor outcome	1.50	1.86

**ADDITIONAL RATIONALE**

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

A consensus panel of the American College of Radiology (ACR) and Society of Interventional Radiology (SIR) consisted of physicians who reviewed the survey results and believe that the median value overestimates physician work for ultrasound localization for venous access. Ultrasound is typically used for localization of a suitable access point and for confirming entry into the selected vein. A comparable ultrasound code has not been previously valued, and the respondents had difficulty finding a representative reference service. We believe that this service typically involves a survey of possible venous access sites, determining which site is best and confirming guidance of the needle into the vein. Our consensus recommendation is 0.30 RVW.



CVA 000-global PE details (Post-RUC May 21 conference call)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	L1		L2		L10		L11	
		36555 Insertion of non-tunneled centrally inserted central venous catheter, under 5 years of age		36556 Insertion of non-tunneled centrally inserted central venous catheter, age 5 years or older		36568 Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, under 5		36569 Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, age 5	
EM SAME DAY? -->			MAYBE		MAYBE		MAYBE		MAYBE
Conscious Sedation? -->		YES				YES			
GLOBAL PERIOD		000		000		000		000	
LOCATION		NonFac	Fac	NonFac	Fac	NonFac	Fac	NonFac	Fac
TOTAL RN/LPN/MTA TIME	1130	40	3	37	3	40	3	37	3
TOTAL RN (CS) TIME	1033	37				37			
PRE-SERVICE PERIOD TOTAL TIME	1130	9		6		9		6	
SERVICE PERIOD RN (CS) TIME	1033	37				37			
SERVICE PERIOD RN/LPN/MTA TIME	1130	28	3	28	3	28	3	28	3
POST-SERVICE PERIOD TIME	1130	3		3		3		3	
<b>PRE-SERVICE PERIOD</b>									
Complete pre-service diagnostic & referral forms	1130	3		3		3		3	
Coordinate pre-surgery services	1130	3		3		3		3	
Schedule space and equipment in facility	1130								
Provide pre-service education/obtain consent	1130								
Follow-up phone calls & prescriptions	1130	3				3			
<b>SERVICE PERIOD</b>									
<b>Pre-service</b>									
Review charts	1130	2		2		2		2	
Greet patient and provide gowning	1130	3		3		3		3	
Obtain vital signs	1130	5		3		5		3	
Provide pre-service education/obtain consent	1130	5		5		5		5	
Prepare room, equipment, supplies	1130	5		5		5		5	
Prepare and position pt/ monitor pt/ set up IV	1130	2		2		2		2	
Sedate/apply anesthesia	1130			2				2	
Sedate/apply anesthesia	1033	2				2			
<b>Intra-service</b>									
Assist physician in performing procedure									
Assist physician - conscious sedation	1033 (@100%)	20				20			
<b>Post-Service</b>									
Monitor pt/check tubes, monitors, drains	1033	15				15			
Clean room/equipment by physician staff	1130	3		3		3		3	
Clean Scope	1130								
Complete diagnostic forms, lab & X-ray requisitions	1130								
Review/read X-ray, lab, and pathology reports	1130								
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	1130	3		5		3		5	
Discharge day management 99238 --12 minutes 99239 --15 minutes	1130								
Other Clinical Activity follow up phone call			3		3		3		3
<b>POST-SERVICE PERIOD</b>									
Conduct phone calls/call in prescriptions		3		3		3		3	
Other Activity (please specify)									

CVA 000-global PE details (Post-RUC May 21 conference call)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	L1		L2		L10		L11	
		36555	36556	36556	36556	36568	36568	36569	36569
		Insertion of non-tunneled centrally inserted central venous catheter, under 5 years of age	Insertion of non-tunneled centrally inserted central venous catheter, age 5 years or older	Insertion of peripherally inserted central venous catheter (PICC) without subcutaneous port or pump, under 5	Insertion of peripherally inserted central venous catheter (PICC) without subcutaneous port or pump, age 5				
	EM SAME DAY? -->	MAYBE		MAYBE		MAYBE		MAYBE	
	Conscious Sedation? -->	YES				YES			
GLOBAL PERIODS		000		000		000		000	
LOCATION		NonFac	Fac	NonFac	Fac	NonFac	Fac	NonFac	Fac
<b>MEDICAL SUPPLIES</b>									
minimum visit package (multispecialty)	PEAC	1		1		1		1	
CONSCIOUS SEDATIONS PACKAGE	PEAC	1				1			
surgical cap	11305	1		1		1		1	
gloves, sterile	14005	1		1		1		1	
gown, staff, impervious, disposable	11304	1		1		1		1	
surgical mask, with face shield	11301	2		1		2		1	
shoe covers	11307	2		1		2		1	
sterile drapes	14001	1		1		1		1	
tray, disposable prep	11103	1		1		1		1	
swab, alcohol	31101	2		2		2		2	
Xylocaine 1% (ml)	51503	1		1		1		1	
syringe, 1ml	91408	1		1		1		1	
syringe 3 cc	91415	1		1		1		1	
needle, 25 & 26 gauge	91403	1		1		1		1	
Betadine (ml)	52301	10		10		10		10	
hydrogen peroxide (ml)	52303	20		20		20		20	
Heparane, 1000 ups (ml)	53007	5		5		5		5	
saline 0.9% flush syringe (10ml)	cms	1		1		1		1	
Guidewire, STIFF (Diff than item# 93129(Guidewire, stiff, @ \$38.00 per Meditech)	New								
microstick (50.50 split using 1 or 2, 1.5 is average) @ \$42.50 per MEDITECH	New					1.5		1.5	
Non-tunneled catheter kit (including angiographic vessel dilator and vascular sheath) (\$68 Cook)	New	1		1					
Peripheral central venous access catheter without subcutaneous port or pump (\$80 Cook)	HCPCS C2597 C2598					1		1	
Catheter hub segment/repair kit (\$64 Cook)	New								
band aid, 3/4 x 3"	31502	1		1		1		1	
Gauze, sterile 4 x 4	31505	3		3		3		3	
tape	31514	12		12		12		12	
<b>Equipment</b>									
exam table	E11001	1		1		1		1	
exam lamp	E30006	1		1		1		1	
3 channel ECG/BP monitor	E55005	1				1			
infusion pump	E91001	1				1			
oxygen tank	cms	1				1			
pulse oximeter	E55008	1				1			

CVA 000-global PE details (Post-RUC May 21 conference call)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	L14		L17		L21	
		36575	36580	36584	36584	36584	36584
		Repair of tunneled or non-tunneled central venous	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous			
		EM SAME DAY? -->>	YES	YES			
		Conscious Sedation? -->>					
GLOBAL PERIOD		000	000	000	000	000	000
LOCATION		NonFac	Fac	NonFac	Fac	NonFac	Fac
TOTAL RN/LPN/MTA TIME	1130	13	3	35	3	37	18
TOTAL RN (CS) TIME	1033						
PRE-SERVICE PERIOD TOTAL TIME	1130			6		6	15
SERVICE PERIOD RN (CS) TIME	1033						
SERVICE PERIOD RN/LPN/MTA TIME	1130	10	3	26	3	28	3
POST-SERVICE PERIOD TIME	1130	3		3		3	
PRE-SERVICE PERIOD							
Complete pre-service diagnostic & referral forms	1130			3		3	3
Coordinate pre-surgery services	1130			3		3	3
Schedule space and equipment in facility	1130						3
Provide pre-service education/obtain consent	1130						3
Follow-up phone calls & prescriptions	1130						3
SERVICE PERIOD							
Pre-service							
Review charts	1130			2		2	
Greet patient and provide gowning	1130			3		3	
Obtain vital signs	1130			3		3	
Provide pre-service education/obtain consent	1130	2		5		5	
Prepare room, equipment, supplies	1130	3		5		5	
Prepare and position pt/ monitor pt/ set up IV	1130	2				2	
Sedate/apply anesthesia	1130	2		2		2	
Sedate/apply anesthesia	1033						
Intra-service							
Assist physician in performing procedure							
Assist physician - conscious sedation	1033 (@100%)						
Post-Service							
Monitor pt/check tubes, monitors, drains	1033						
Clean room/equipment by physician staff	1130			3		3	
Clean Scope	1130						
Complete diagnostic forms, lab & X-ray requisitions	1130						
Review/read X-ray, lab, and pathology reports	1130						
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	1130	3		5		5	
Discharge day management 99238 --12 minutes 99239 --15 minutes	1130						
Other Clinical Activity follow up phone call			3		3		3
POST-SERVICE PERIOD							
Conduct phone calls/call in prescriptions		3		3		3	
Other Activity (please specify)							

CVA 000-global PE details (Post-RUC May 21 conference call)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	L14		L17		L21	
		36575		36580		36584	
		Repair of tunneled or non-tunneled central venous		Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous		Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous	
EM SAME DAY? -->		YES	YES				
Conscious Sedation? -->							
GLOBAL PERIOD		000		000		000	
LOCATION		NonFac	Fac	NonFac	Fac	NonFac	Fac
<b>MEDICAL SUPPLIES</b>							
minimum visit package (multispecialty)	PEAC			1		1	
CONSCIOUS SEDATIONS PACKAGE	PEAC						
surgical cap	11305	1		1		1	
gloves, sterile	14005	1		1		1	
gown, staff, impervious, disposable	11304	1		1		1	
surgical mask, with face shield	11301	1		1		1	
shoe covers	11307	1		1		1	
sterile drapes	14001	1		1		1	
tray, disposable prep	11103	1		1		1	
swab, alcohol	31101	2		2		2	
Xylocaine 1% (ml)	51503	1		1		1	
syringe, 1ml	91408	1		1		1	
syringe 3 cc	91415	1		1		1	
needle, 25 & 26 gauge	91403	1		1		1	
Betadine (ml)	52301	10		10		10	
hydrogen peroxide (ml)	52303	20		20		20	
Hepanone, 1000 ups (ml)	53007	5		5		5	
saline 0.9% flush syringe (10ml)	cms	1		1		1	
Guidewire, STIFF (Diff than item# 93129(Guidewire, stiff, @ \$38.00 per Meditech)	New			1		1	
microstick (50.50 split using 1 or 2, 1.5 is average) @ \$42.50 per MEDITECH	New						
Non-tunneled catheter kit (including angiographic vessel dilator and vascular sheath) (\$68 Cook)	New			1			
Peripheral central venous access catheter without subcutaneous port or pump (\$80 Cook)	HCPCS C2597 C2598					1	
Catheter hub segment/repair kit (\$64 Cook)	New	1					
band aid, 3/4 x 3"	31502	1		1		1	
Gauze, sterile 4 x 4	31505	3		3		3	
tape	31514	12		12		12	
<b>Equipment</b>							
exam table	E11001	1		1		1	
exam lamp	E30006	1		1		1	
3 channel ECG/BP monitor	E55005						
infusion pump	E91001						
oxygen tank	cms						
pulse oximeter	E55008						

CVA PE details (RUC April 2003)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	L29	
		36597	
		Repositioning of previously placed central venous catheter under fluoroscopic guidance	
GLOBAL PERIOD		000	
LOCATION		NonFac	Fac
<b>TOTAL CLINICAL LABOR TIME</b>	1130	48.0	0.0
<b>PRE-SERVICE PERIOD TOTAL TIME</b>	1130	6.0	0.0
<b>SERVICE PERIOD TOTAL TIME</b>	1130	39.0	0.0
<b>POST-SERVICE PERIOD TIME</b>	1130	3.0	0.0
<b>PRE-SERVICE PERIOD</b>			
Complete pre-service diagnostic & referral forms	1130	3	
Coordinate pre-surgery services	1130	3	
Schedule space and equipment in facility	1130		
Provide pre-service education/obtain consent	1130		
Follow-up phone calls & prescriptions	1130		
Other Clinical Activity (please specify)			
<b>SERVICE PERIOD</b>			
<b>Pre-service</b>			
Review charts	1130	5	
Greet patient and provide gowning	1130	3	
Obtain vital signs	1130	3	
Provide pre-service education/obtain consent			
Prepare room, equipment, supplies	1130	5	
Prepare and position patient/ monitor patient/ set up IV	1130	2	
Sedate/apply anesthesia			
<b>Intra-service</b>			
Assist physician in performing procedure			
<b>Post-Service</b>			
Monitor pt. following service/check tubes, monitors, drains	1130	15	
Clean room/equipment by physician staff	1130	3	
Complete diagnostic forms, lab & X-ray requisitions			
Review/read X-ray, lab, and pathology reports			
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	1130	3	
Coordination of Care			
Discharge day management 99238 --12 minutes 99239 --15 minutes			
Other Clinical Activity (please specify):			
<b>POST-SERVICE PERIOD</b>			
Conduct phone calls/call in prescriptions	1130	3	
Other Activity (please specify)			

<b>MEDICAL SUPPLIES</b>			
tray, disposable prep	11103	1	
drape, sheet	11106	1	
patient gown	11107	1	
exam table paper	11111	7	
pillow case, disposable	11112	1	
surgical cap	11305	2	
mask, surgical	11306	2	
shoe covers	11307	2	
thermometer probe cover, disposable	11509	1	
sterile drapes	14001	1	
gloves, sterile	14005	6	
sterile surgical gown	14008	3	
swab, alcohol	31101	2	
band aid, 3/4 x 3"	31502	1	
Gauze, sterile 4 x 4	31505	3	
tape	31514	12	
lidocaine	51502	1	
Betadine	52301	1	
hydrogen peroxide	52303	1	
Heparine, 1000 ups	53007	5	
needle, butterfly 20-25g	91105	1	
syringe, 3cc, 20-25g needle	91406	1	
syringe, 1ml	91408	1	
saline flush	CPEP 10 ml \$2.30	1	
Guidewire, STIFF (Standard guidewire 93129 NOT standard of care a stiff wire must be used.)(Guidewire, stiff, \$38.00 each per manufacturer Meditech)	NO CODE \$38.00	1	
<b>Equipment</b>			
exam table	E11001	1	
exam lamp	E30006	1	

CVA 010-global PE details (Post-RUC May 21 conference call)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	L3		L4		L5		L6	
		36557 Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump, under 5 years of age		36558 Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump, age 5 years or older		36560 Insertion of tunneled centrally inserted central venous access device with subcutaneous port; under 5 years of age		36561 Insertion of tunneled centrally inserted central venous access device with subcutaneous port; age 5 years or older	
EM SAME DAY? -->									
Conscious Sedation? -->		YES		YES		YES		YES	
GLOBAL PERIOD		10		10		10		10	
LOCATION		NonFac	Fac	NonFac	Fac	NonFac	Fac	NonFac	Fac
TOTAL RN/LPN/MTA TIME	1130	67	59	67	59	67	59	67	59
TOTAL RN (CS) TIME	1033	47		47		62		62	
PRE-SERVICE PERIOD TOTAL TIME	1130	9	26	9	26	9	26	9	26
SERVICE PERIOD RN (CS) TIME	1033	47		47		62		62	
SERVICE PERIOD RN/LPN/MTA TIME	1130	28	6	28	6	28	6	28	6
POST-SERVICE PERIOD TIME	1130	30	27	30	27	30	27	30	27
<b>PRE-SERVICE PERIOD</b>									
Complete pre-service diagnostic & referral forms	1130	3	5	3	5	3	5	3	5
Coordinate pre-surgery services	1130	3	6	3	6	3	6	3	6
Schedule space and equipment in facility	1130		5		5		5		5
Provide pre-service education/obtain consent	1130		7		7		7		7
Follow-up phone calls & prescriptions	1130	3	3	3	3	3	3	3	3
Other Clinical Activity (please specify)									
<b>SERVICE PERIOD</b>									
<b>Pre-service</b>									
Review charts	1130	2		2		2		2	
Greet patient and provide gowning	1130	3		3		3		3	
Obtain vital signs	1130	5		5		5		5	
Provide pre-service education/obtain consent	1130	5		5		5		5	
Prepare room, equipment, supplies	1130	5		5		5		5	
Prepare and position patient/ monitor patient/ set up IV	1130	2		2		2		2	
Sedate/apply anesthesia	1130								
Sedate/apply anesthesia	1033	2		2		2		2	
<b>Intra-service</b>									
Assist physician in performing procedure									
Assist physician - conscious sedation	1033 (@100%)	30		30		45		45	
<b>Post-Service</b>									
Monitor pt following service/check tubes, monitors, drains	1033	15		15		15		15	
Clean room/equipment by physician staff	1130	3		3		3		3	
Clean Scope	1130								
Complete diagnostic forms, lab & X-ray requisitions	1130								
Review/read X-ray, lab, and pathology reports	1130								
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	1130	3		3		3		3	
Discharge day management 99238 --12 minutes 99239 --15 minutes	1130		6		6		6		6
Other Clinical Activity (please specify)									
<b>POST-SERVICE PERIOD</b>									
Conduct phone calls/call in prescriptions		3		3		3		3	
<b>List Number and Level of Office Visits</b>									
99211 16 minutes									
99212 27 minutes		1	1	1	1	1	1	1	1
99213 36 minutes									
99214 53 minutes									
99215 63 minutes									
<b>Total Office Visit Time</b>	1130	27	27	27	27	27	27	27	27
Other Activity (please specify)									

CVA 010-global PE details (Post-RUC May 21 conference call)		L3		L4		L5		L6	
		36557 Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; under 5 years of age		36558 Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older		36560 Insertion of tunneled centrally inserted central venous access device with subcutaneous port; under 5 years of age		36561 Insertion of tunneled centrally inserted central venous access device with subcutaneous port; age 5 years or older	
CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE									
EM SAME DAY? -->>									
Conscious Sedation? -->>		YES		YES		YES		YES	
GLOBAL PERIOD		10		10		10		10	
LOCATION		NonFac Fac		NonFac Fac		NonFac Fac		NonFac Fac	
MEDICAL SUPPLIES									
minimum visit package (multispecialty)	PEAC pack	2	1	2	1	2	1	2	1
post-op incision care kit	PEAC kit	1	1	1	1	1	1	1	1
Conscious Sedation Package	PEAC	1		1		1		1	
surgical cap	11305	1		1		1		1	
gloves, sterile	14005	1		1		1		1	
gown, staff, impervious, disposable	11304	1		1		1		1	
surgical mask, with face shield	11301	2		2		2		2	
shoe covers	11307	2		2		2		2	
tray, disposable prep	11103	1		1		1		1	
swab, alcohol	31101	2		2		2		2	
Xylocaine 1% (ml)	51503	1		1		1		1	
syringe, 1ml	91408	1		1		1		1	
syringe 3 cc	91415	1		1		1		1	
needle, 25 & 26 gauge	91403	1		1		1		1	
hydrogen peroxide (ml)	52303	20		20		20		20	
scalpel with blade #11,15,20	11504	1		1		1		1	
silver nitrate stick	52304	1		1		1		1	
Heparine, 1000 ups	53007	5		5		5		5	
saline 0.9% flush syringe	CMS	1		1		1		1	
microstick (50:50 split using 1 or 2, 1.5 is average) @ \$42.50 per MEDITECH	New	1.5		1.5		1.5		1.5	
Guidewire, STIFF (Diff than item# 93129(Guidewire, stiff, @ \$38.00 per Medtech)	New	1		1		1		1	
Tunneled catheter kit (including angiographic vessel dilator and vascular sheath) (\$104 Cook)	New	1		1					
Tunneled centrally inserted central venous access device (dual catheters) (\$250-Tesio)	New								
Tunneled catheter kit (including angiographic vessel dilator and vascular sheath) with subcutaneous port (\$435 Cook)	New					1		1	
venous access port, implantable	HCPCS: C1036					1		1	
Peripheral access device with subcutaneous port (\$583 Cook)	New								
Non-tunneled central venous catheter (\$68 Cook)	New								
CVA Device REPAIR KIT	New								
vicryl suture 4-0 and 5-0	31708	1		1		1		1	
Gauze, sterile 4 x 4	31505	2		2		2		2	
tape (inch)	31514	6		6		6		6	
<b>Equipment</b>									
exam table	E11001	1	1	1	1	1	1	1	1
exam lamp	E30006	1	1	1	1	1	1	1	1
3 channel ECG/BP monitor	E55005	1		1		1		1	
infusion pump	E91001	1		1		1		1	
oxygen tank	cms	1		1		1		1	
pulse oximeter	E55008	1		1		1		1	

CVA 010-global PE details (Post-RUC May 21 conference call)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	L7		L8		L9		L12	
		36563		36565		36566		36570	
		Insertion of tunneled centrally inserted central venous access device with subcutaneous pump		Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites, without subcutaneous port or pump; (eg, Tesio type catheter)		Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites, with subcutaneous port(s)		Insertion of peripherally inserted central venous access device with subcutaneous port, under 5 years of age	
EM SAME DAY? -->				maybe					
Conscious Sedation? -->	YES	YES	YES	YES	YES	YES	YES	YES	
GLOBAL PERIOD	10	10	10	10	10	10	10	10	
LOCATION	NonFac	Fac	NonFac	Fac	NonFac	Fac	NonFac	Fac	
TOTAL RN/LPN/MTA TIME	1130	67	59	67	33	67	59	67	59
TOTAL RN (CS) TIME	1033	77		62		77		62	
PRE-SERVICE PERIOD TOTAL TIME	1130	9	26	9		9	26	9	26
SERVICE PERIOD RN (CS) TIME	1033	77		62		77		62	
SERVICE PERIOD RN/LPN/MTA TIME	1130	28	6	28	6	28	6	28	6
POST-SERVICE PERIOD TIME	1130	30	27	30	27	30	27	30	27
<b>PRE-SERVICE PERIOD</b>									
Complete pre-service diagnostic & referral forms	1130	3	5	3		3	5	3	5
Coordinate pre-surgery services	1130	3	6	3		3	6	3	6
Schedule space and equipment in facility	1130		5				5		5
Provide pre-service education/obtain consent	1130		7				7		7
Follow-up phone calls & prescriptions	1130	3	3	3		3	3	3	3
Other Clinical Activity (please specify)									
<b>SERVICE PERIOD</b>									
<b>Pre-service</b>									
Review charts	1130	2		2		2		2	
Greet patient and provide gowning	1130	3		3		3		3	
Obtain vital signs	1130	5		5		5		5	
Provide pre-service education/obtain consent	1130	5		5		5		5	
Prepare room, equipment, supplies	1130	5		5		5		5	
Prepare and position patient/ monitor patient/ set up IV	1130	2		2		2		2	
Sedate/apply anesthesia	1130								
Sedate/apply anesthesia	1033	2		2		2		2	
<b>Intra-service</b>									
Assist physician in performing procedure									
Assist physician - conscious sedation	1033 (@100%)	60		45		60		45	
<b>Post-Service</b>									
Monitor pt following service/check tubes, monitors, drains	1033	15		15		15		15	
Clean room/equipment by physician staff	1130	3		3		3		3	
Clean Scope	1130								
Complete diagnostic forms, lab & X-ray requisitions	1130								
Review/read X-ray, lab, and pathology reports	1130								
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	1130	3		3		3		3	
Discharge day management 99238 --12 minutes 99239 --15 minutes	1130		6		6		6		6
Other Clinical Activity (please specify)									
<b>POST-SERVICE PERIOD</b>									
Conduct phone calls/call in prescriptions		3		3		3		3	
<b>List Number and Level of Office Visits</b>									
99211 16 minutes									
99212 27 minutes		1	1	1	1	1	1	1	1
99213 36 minutes									
99214 53 minutes									
99215 63 minutes									
<b>Total Office Visit Time</b>	1130	27	27	27	27	27	27	27	27
Other Activity (please specify)									

CVA 010-global PE details (Post-RUC May 21 conference call)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	L7		L8		L9		L12	
		36563		36565		36566		36570	
		Insertion of tunneled centrally inserted central venous access device with subcutaneous pump		Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites, without subcutaneous port or pump, (eg, Tesio type catheter)		Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites, with subcutaneous port(s)		Insertion of peripherally inserted central venous access device with subcutaneous port, under 5 years of age	
EM SAME DAY? -->				maybe					
Conscious Sedation? -->		YES		YES		YES		YES	
GLOBAL PERIOD		10		10		10		10	
LOCATION		NonFac	Fac	NonFac	Fac	NonFac	Fac	NonFac	Fac
MEDICAL SUPPLIES									
minimum visit package (multispecialty)	PEAC pack	2	1	2	1		1	2	1
post-op incision care kit	PEAC kit	1	1	1	1		1	1	1
Conscious Sedation Package	PEAC	1		1		1		1	
surgical cap	11305	1		1		1		1	
gloves, sterile	14005	1		1		1		1	
gown, staff, impervious, disposable	11304	1		1		1		1	
surgical mask, with face shield	11301	2		2		2		2	
shoe covers	11307	2		2		2		2	
tray, disposable prep	11103	1		1		1		1	
swab, alcohol	31101	2		2		2		2	
Xylocaine 1% (ml)	51503	1		2		2		1	
synnrg, 1ml	91408	1		1		1		1	
synnrg 3 cc	91415	1		1		1		1	
needle, 25 & 26 gauge	91403	1		1		1		1	
hydrogen peroxide (ml)	52303	20		20		20		20	
scapel with blade #11,15,20	11504	1		1		1		1	
silver nitrate stick	52304	1		1		1		1	
Heparine, 1000 ups	53007	5		5		5		5	
saline 0.9% flush syringe	CMS	1		1		1		1	
microstick (50 50 split using 1 or 2, 1 5 is average) @ \$42 50 per MEDITECH	New	1.5		1.5		1.5		1.5	
Guidewire, STIFF (Diff than item# 93129(Guidewire, stiff, @ \$38 00 per Meditech)	New	1		2		2		1	
Tunneled catheter kit (including angiographic vessel dilator and vascular sheath) (\$104 Cook)	New							1	
Tunneled centrally inserted central venous access device (dual catheters) (\$250-Tesio)	New			1		1			
Tunneled catheter kit (including angiographic vessel dilator and vascular sheath) with subcutaneous port (\$435 Cook)	New	1							
venous access port, implantable	HCPCS: C1036								
Peripheral access device with subcutaneous port (\$583 Cook)	New							1	
Non-tunneled central venous catheter (\$68 Cook)	New								
CVA Device REPAIR KIT	New								
vicryl suture 4-0 and 5-0	31708	1		2		2		1	
Gauze, sterile 4 x 4	31505	2		2		4		2	
tape (inch)	31514	6		9		12		6	
Equipment									
exam table	E11001	1	1	1	1	1	1	1	1
exam lamp	E30006	1	1	1	1	1	1	1	1
3 channel ECG/BP monitor	E55005	1		1		1		1	
infusion pump	E91001	1		1		1		1	
oxygen tank	cms	1		1		1		1	
pulse oximeter	E55008	1		1		1		1	

CVA 010-global PE details (Post-RUC May 21 conference call)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	L13		L15		L16		L18	
		36571	36576	36576	36576	36578	36578	36581	36581
		Insertion of peripherally inserted central venous access device with subcutaneous port, age 5 years or older	Repair of central venous access device with subcutaneous port or pump, central or peripheral insertion site	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	Replacement, complete, of a tunneled centrally inserted central venous catheter without subcutaneous port or pump, through same venous access				
EM SAME DAY? -->									
Conscious Sedation? -->		YES		YES		YES		YES	
GLOBAL PERIOD		10		10		10		10	
LOCATION		NonFac	Fac	NonFac	Fac	NonFac	Fac	NonFac	Fac
TOTAL RN/LPN/MTA TIME	1130	67	59	67	33	67	59	67	33
TOTAL RN (CS) TIME	1033	67		50		47		47	
PRE-SERVICE PERIOD TOTAL TIME	1130	9	26	9		9	26	9	
SERVICE PERIOD RN (CS) TIME	1033	67		50		47		47	
SERVICE PERIOD RN/LPN/MTA TIME	1130	28	6	28	6	28	6	28	6
POST-SERVICE PERIOD TIME	1130	30	27	30	27	30	27	30	27
PRE-SERVICE PERIOD									
Complete pre-service diagnostic & referral forms	1130	3	5	3		3	5	3	
Coordinate pre-surgery services	1130	3	6	3		3	6	3	
Schedule space and equipment in facility	1130		5				5		
Provide pre-service education/obtain consent	1130		7				7		
Follow-up phone calls & prescriptions	1130	3	3	3		3	3	3	
Other Clinical Activity (please specify)									
SERVICE PERIOD									
Pre-service									
Review charts	1130	2		2		2		2	
Greet patient and provide gowning	1130	3		3		3		3	
Obtain vital signs	1130	5		5		5		5	
Provide pre-service education/obtain consent	1130	5		5		5		5	
Prepare room, equipment, supplies	1130	5		5		5		5	
Prepare and position patient/ monitor patient/ set up IV	1130	2		2		2		2	
Sedate/apply anesthesia	1130								
Sedate/apply anesthesia	1033	2		2		2		2	
Intra-service									
Assist physician in performing procedure									
Assist physician - conscious sedation	1033 (@100%)	50		33		30		30	
Post-Service									
Monitor pt following service/check tubes, monitors, drains	1033	15		15		15		15	
Clean room/equipment by physician staff	1130	3		3		3		3	
Clean Scope	1130								
Complete diagnostic forms, lab & X-ray requisitions	1130								
Review/read X-ray, lab, and pathology reports	1130								
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	1130	3		3		3		3	
Discharge day management 99238 --12 minutes 99239 --15 minutes	1130		6		6		6		6
Other Clinical Activity (please specify)									
POST-SERVICE PERIOD									
Conduct phone calls/call in prescriptions		3		3		3		3	
List Number and Level of Office Visits									
99211 16 minutes									
99212 27 minutes		1	1	1	1	1	1	1	1
99213 36 minutes									
99214 53 minutes									
99215 63 minutes									
Total Office Visit Time	1130	27	27	27	27	27	27	27	27
Other Activity (please specify)									

CVA 010-global PE details (Post-RUC May 21 conference call)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	L13		L15		L16		L18	
		36571		36576		36578		36581	
		Insertion of peripherally inserted central venous access device with subcutaneous port, age 5 years or older		Repair of central venous access device with subcutaneous port or pump, central or peripheral insertion site		Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site		Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	
EM SAME DAY? -->									
Conscious Sedation? -->									
		YES		YES		YES		YES	
GLOBAL PERIOD		10		10		10		10	
LOCATION		NonFac	Fac	NonFac	Fac	NonFac	Fac	NonFac	Fac
MEDICAL SUPPLIES									
minimum visit package (multispecialty)	PEAC pack	2	1	2	1	2	1	2	1
post-op incision care kit	PEAC kit	1	1	1	1	1	1	1	1
Conscious Sedation Package	PEAC	1		1		1		1	
surgical cap	11305	1		1		1		1	
gloves, sterile	14005	1		1		1		1	
gown, staff, impervious, disposable	11304	1		1		1		1	
surgical mask, with face shield	11301	2		2		2		2	
shoe covers	11307	2		2		2		2	
tray, disposable prep	11103	1		1		1		1	
swab, alcohol	31101	2		2		2		2	
Xylocaine 1% (ml)	51503	1		1		1		1	
syringe, 1ml	91408	1		1		1		1	
syringe 3 cc	91415	1		1		1		1	
needle, 25 & 26 gauge	91403	1		1		1		1	
hydrogen peroxide (ml)	52303	20		20		20		20	
scapel with blade #11,15,20	11504	1		1		1		1	
silver nitrate stick	52304	1		1		1		1	
Heparine, 1000 ups	53007	5		5		5		5	
saline 0.9% flush syringe	CMS	1		1		1		1	
microstick (50 50 split using 1 or 2, 1.5 is average) @ \$42 50 per MEDITECH	New	1.5		1.5		1.5		1.5	
Guidewire, STIFF (Diff than item# 93129(Guidewire, stiff, @ \$38 00 per Meditech)	New	1		1		1		2	
Tunneled catheter kit (including angiographic vessel dilator and vascular sheath) (\$104 Cook)	New							1	
Tunneled centrally inserted central venous access device (dual catheters) (\$250-Tesio)	New								
Tunneled catheter kit (including angiographic vessel dilator and vascular sheath) with subcutaneous port (\$435 Cook)	New								
venous access port, implantable	HCPCS: C1036								
Peripheral access device with subcutaneous port (\$583 Cook)	New	1							
Non-tunneled central venous catheter (\$68 Cook)	New					1			
CVA Device REPAIR KIT	New			1					
vicryl suture 4-0 and 5-0	31708	1		1		1		1	
Gauze, sterile 4 x 4	31505	2		2		2		2	
tape (inch)	31514	6		6		6		6	
Equipment									
exam table	E11001	1	1	1	1	1	1	1	1
exam lamp	E30006	1	1	1	1	1	1	1	1
3 channel ECG/BP monitor	E55005	1		1		1		1	
infusion pump	E91001	1		1		1		1	
oxygen tank	cms	1		1		1		1	
pulse oximeter	E55008	1		1		1		1	

CVA 010-global PE details (Post-RUC May 21 conference call)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	L19		L20		L22		L23		
		36582	36583	36585	36589	36582	36583	36585	36589	
		Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous port, through same venous access	Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous pump, through same venous access	Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access	Removal of tunneled central venous catheter, without subcutaneous port or pump					
EM SAME DAY? -->										
Conscious Sedation? -->		YES		YES		YES				
GLOBAL PERIOD		10		10		10		10		
LOCATION		NonFac	Fac	NonFac	Fac	NonFac	Fac	NonFac	Fac	
TOTAL RN/LPN/MTA TIME	1130	67	59	67	59	67	59	60	37	
TOTAL RN (CS) TIME	1033	77		77		77				
PRE-SERVICE PERIOD TOTAL TIME	1130	9	26	9	26	9	26	9	15	
SERVICE PERIOD RN (CS) TIME	1033	77		77		77				
SERVICE PERIOD RN/LPN/MTA TIME	1130	28	6	28	6	28	6	32	6	
POST-SERVICE PERIOD TIME	1130	30	27	30	27	30	27	19	16	
<b>PRE-SERVICE PERIOD</b>										
Complete pre-service diagnostic & referral forms	1130	3	5	3	5	3	5	3	3	
Coordinate pre-surgery services	1130	3	6	3	6	3	6	3	3	
Schedule space and equipment in facility	1130		5		5		5		3	
Provide pre-service education/obtain consent	1130		7		7		7		3	
Follow-up phone calls & prescriptions	1130	3	3	3	3	3	3	3	3	
Other Clinical Activity (please specify)										
<b>SERVICE PERIOD</b>										
<b>Pre-service</b>										
Review charts	1130	2		2		2		2		
Greet patient and provide gowning	1130	3		3		3		3		
Obtain vital signs	1130	5		5		5		5		
Provide pre-service education/obtain consent	1130	5		5		5		5		
Prepare room, equipment, supplies	1130	5		5		5		5		
Prepare and position patient/ monitor patient/ set up IV	1130	2		2		2		2		
Sedate/apply anesthesia	1130							2		
Sedate/apply anesthesia	1033	2		2		2				
<b>Intra-service</b>										
Assist physician in performing procedure										
Assist physician - conscious sedation	1033 (@100%)	60		60		60				
<b>Post-Service</b>										
Monitor pt following service/check tubes, monitors, drains	1033	15		15		15				
Clean room/equipment by physician staff	1130	3		3		3		3		
Clean Scope	1130									
Complete diagnostic forms, lab & X-ray requisitions	1130									
Review/read X-ray, lab, and pathology reports	1130									
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	1130	3		3		3		5		
Discharge day management 99238 --12 minutes 99239 --15 minutes	1130		6		6		6		6	
Other Clinical Activity (please specify)										
<b>POST-SERVICE PERIOD</b>										
Conduct phone calls/call in prescriptions		3		3		3		3		
<b>List Number and Level of Office Visits</b>										
99211 16 minutes								1	1	
99212 27 minutes		1	1	1	1	1	1			
99213 36 minutes										
99214 53 minutes										
99215 63 minutes										
<b>Total Office Visit Time</b>	1130	27	27	27	27	27	27	16	16	
Other Activity (please specify)										

CVA 010-global PE details (Post-RUC May 21 conference call)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	L19		L20		L22		L23	
		36582		36583		36585		36589	
		Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous port, through same venous access		Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous pump, through same venous access		Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port through same venous access		Removal of tunneled central venous catheter, without subcutaneous port or pump	
EM SAME DAY? -->									
Conscious Sedation? -->									
GLOBAL PERIOD									
LOCATION									
MEDICAL SUPPLIES									
minimum visit package (multispecialty)									
post-op incision care kit									
Conscious Sedation Package									
surgical cap									
gloves, sterile									
gown, staff, impervious, disposable									
surgical mask, with face shield									
shoe covers									
tray, disposable prep									
swab, alcohol									
Xylocaine 1% (ml)									
syringe, 1ml									
syringe 3 cc									
needle, 25 & 26 gauge									
hydrogen peroxide (ml)									
scapel with blade #11,15,20									
silver nitrate stick									
Heparine, 1000 ups									
saline 0.9% flush syringe									
microstick (50.50 split using 1 or 2, 1.5 is average) @ \$42.50 per MEDITECH									
Guidewire, STIFF (Diff than item# 93129(Guidewire, stiff, @ \$38.00 per Meditech)									
Tunneled catheter kit (including angiographic vessel dilator and vascular sheath) (\$104 Cook)									
Tunneled centrally inserted central venous access device (dual catheters) (\$250-Tesio)									
Tunneled catheter kit (including angiographic vessel dilator and vascular sheath) with subcutaneous port (\$435 Cook)									
venous access port, implantable									
Peripheral access device with subcutaneous port (\$583 Cook)									
Non-tunneled central venous catheter (\$68 Cook)									
CVA Device REPAIR KIT									
vicryl suture 4-0 and 5-0									
Gauze, sterile 4 x 4									
tape (inch)									
Equipment									
exam table									
exam lamp									
3 channel ECG/BP monitor									
infusion pump									
oxygen tank									
pulse oximeter									
		10		10		10		10	
		NonFac	Fac	NonFac	Fac	NonFac	Fac	NonFac	Fac
	PEAC pack	2	1	2	1	2	1	2	1
	PEAC kit	1	1	1	1	1	1	1	1
	PEAC	1		1		1			
	11305	1		1		1		1	
	14005	1		1		1		1	
	11304	1		1		1		1	
	11301	2		2		2		1	
	11307	2		2		2		1	
	11103	1		1		1		1	
	31101	2		2		2		2	
	51503	1		1		1			
	91408	1		1		1			
	91415	1		1		1			
	91403	1		1		1			
	52303	20		20		20		20	
	11504	1		1		1			
	52304	1		1		1		1	
	53007	5		5		5			
	CMS	1		1		1			
	New	1.5		1.5		1.5			
	New	1		1					
	New			1		1			
	New								
	New	1							
	HCPCS: C1036			1					
	New					1			
	New								
	New								
	31708	1		1		1		1	
	31505	2		2		2		2	
	31514	6		6		6		12	
	E11001	1	1	1	1	1	1	1	1
	E30006	1	1	1	1	1	1	1	1
	E55005	1		1		1			
	E91001	1		1		1			
	cms	1		1		1			
	E55008	1		1		1			

CVA 010-global PE details (Post-RUC May 21 conference call)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	L24	
		36590 Removal of tunneled central venous access device with subcutaneous port or pump, central or peripheral insertion	
EM SAME DAY? -->			
Conscious Sedation? -->		YES	
GLOBAL PERIOD		10	
LOCATION		NonFac	Fac
TOTAL RN/LPN/MTA TIME	1130	67	48
TOTAL RN (CS) TIME	1033	47	
PRE-SERVICE PERIOD TOTAL TIME	1130	9	15
SERVICE PERIOD RN (CS) TIME	1033	47	
SERVICE PERIOD RN/LPN/MTA TIME	1130	28	6
POST-SERVICE PERIOD TIME	1130	30	27
<b>PRE-SERVICE PERIOD</b>			
Complete pre-service diagnostic & referral forms	1130	3	3
Coordinate pre-surgery services	1130	3	3
Schedule space and equipment in facility	1130		3
Provide pre-service education/obtain consent	1130		3
Follow-up phone calls & prescriptions	1130	3	3
Other Clinical Activity (please specify)			
<b>SERVICE PERIOD</b>			
<b>Pre-service</b>			
Review charts	1130	2	
Greet patient and provide gowning	1130	3	
Obtain vital signs	1130	5	
Provide pre-service education/obtain consent	1130	5	
Prepare room, equipment, supplies	1130	5	
Prepare and position patient/ monitor patient/ set up IV	1130	2	
Sedate/apply anesthesia	1130		
Sedate/apply anesthesia	1033	2	
<b>Intra-service</b>			
Assist physician in performing procedure			
Assist physician - conscious sedation	1033 (@100%)	30	
<b>Post-Service</b>			
Monitor pt following service/check tubes, monitors, drains	1033	15	
Clean room/equipment by physician staff	1130	3	
Clean Scope	1130		
Complete diagnostic forms, lab & X-ray requisitions	1130		
Review/read X-ray, lab, and pathology reports	1130		
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	1130	3	
Discharge day management 99238 --12 minutes 99239 --15 minutes	1130		6
Other Clinical Activity (please specify)			
<b>POST-SERVICE PERIOD</b>			
Conduct phone calls/call in prescriptions		3	
<b>List Number and Level of Office Visits</b>			
99211 16 minutes			
99212 27 minutes		1	1
99213 36 minutes			
99214 53 minutes			
99215 63 minutes			
<b>Total Office Visit Time</b>	1130	27	27
Other Activity (please specify)			

<b>CVA 010-global PE details (Post-RUC May 21 conference call)</b>	<b>CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE</b>	<b>L24</b>	
		<b>36590</b>	Removal of tunneled central venous access device with subcutaneous port or pump, central or peripheral insertion
<b>EM SAME DAY? --&gt;</b>			
<b>Conscious Sedation? --&gt;</b>		<b>YES</b>	
<b>GLOBAL PERIOD</b>		<b>10</b>	
<b>LOCATION</b>		<b>NonFac</b>	<b>Fac</b>
<b>MEDICAL SUPPLIES</b>			
<b>minimum visit package (multispecialty)</b>	<b>PEAC pack</b>	<b>2</b>	<b>1</b>
<b>post-op incision care kit</b>	<b>PEAC kit</b>		
<b>Conscious Sedation Package</b>	<b>PEAC</b>	<b>1</b>	
surgical cap	11305	1	
gloves, sterile	14005	1	
gown, staff, impervious, disposable	11304	1	
surgical mask, with face shield	11301	2	
shoe covers	11307	2	
tray, disposable prep	11103	1	
swab, alcohol	31101	2	
Xylocaine 1% (ml)	51503	1	
syringe, 1ml	91408	1	
syringe 3 cc	91415	1	
needle, 25 & 26 gauge	91403	1	
hydrogen peroxide (ml)	52303	20	
scapel with blade #11,15,20	11504	1	
silver nitrate stick	52304	1	
Heparine, 1000 ups	53007		
saline 0.9% flush syringe	CMS	1	
microstick (50.50 split using 1 or 2, 1.5 is average) @ \$42.50 per MEDITECH	New	1.5	
Guidewire, STIFF (Diff than item# 93129(Guidewire, stiff, @ \$38.00 per Meditech)	New	1	
Tunneled catheter kit (including angiographic vessel dilator and vascular sheath) (\$104 Cook)	New		
Tunneled centrally inserted central venous access device (dual catheters) (\$250-Tesio)	New		
Tunneled catheter kit (including angiographic vessel dilator and vascular sheath) with subcutaneous port (\$435 Cook)	New		
venous access port, implantable	<b>HCPCS: C1036</b>		
Peripheral access device with subcutaneous port (\$583 Cook)	New		
Non-tunneled central venous catheter (\$68 Cook)	New		
<b>CVA Device REPAIR KIT</b>	<b>New</b>		
vicryl suture 4-0 and 5-0	31708	1	
Gauze, sterile 4 x 4	31505	2	
tape (inch)	31514	12	
<b>Equipment</b>			
exam table	E11001	1	1
exam lamp	E30006	1	1
3 channel ECG/BP monitor	E55005	1	
infusion pump	E91001	1	
oxygen tank	cms	1	
pulse oximeter	E55008	1	

CVA PE details (RUC April 2003)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	L27		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	L28	
		75998 Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes			76937 Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel	
GLOBAL PERIOD		ZZZ			ZZZ	
LOCATION		NonFac	Fac		NonFac	Fac
<b>TOTAL CLINICAL LABOR TIME</b>	6030	46		6036	15	
PRE-SERVICE PERIOD TOTAL TIME	6030			6036		
SERVICE PERIOD TOTAL TIME	6030	46		6036	15	
POST-SERVICE PERIOD TIME	6030			6036		
<b>PRE-SERVICE PERIOD</b>						
Other Clinical Activity (please specify)						
<b>SERVICE PERIOD</b>						
<b>Pre-service</b>						
Review charts	6030	2		6036		
Greet patient and provide gowning						
Obtain vital signs						
Provide pre-service education/obtain consent						
Prepare room, equipment, supplies	6030	3		6036		
Prepare and position patient/ monitor patient/ set up IV	6030	3		6036		
Sedate/apply anesthesia						
<b>Intra-service</b>						
Assist physician in performing procedure	6030	30		6036	10	
<b>Post-Service</b>						
Monitor pt following service/check tubes, monitors, drains						
Clean room/equipment by physician staff	6030	3		6036		
Clean Scope						
Complete diagnostic forms, lab & X-ray requisitions						
Review/read X-ray, lab, and pathology reports						
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
Discharge day management 99238 --12 minutes 99239 --15 minutes						
Other Activity Post procedure film development and hanging of films	6030	5		6036	5	
<b>POST-SERVICE PERIOD</b>						
Other Activity						

CVA PE details (RUC April 2003)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	L27 75998 Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	L28 76937 Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel	
		GLOBAL PERIOD	ZZZ		ZZZ	
LOCATION		NonFac	Fac		NonFac	Fac
<b>MEDICAL SUPPLIES</b>						
sterile drapes	14001	3		14001	2	
surgical cap	11305	1		11305		
mask, surgical	11306	1		11306		
shoe covers	11307	1		11307		
gloves, sterile	14005	1		14005		
sterile surgical gown	14008	1		14008		
film 14x17	73402	1		73402	1	
film jacket	73405	1		73405	1	
sani-wipe	11113			11113	5	
condoms	11514			11514	1	
transducer wipe	11520			11520	2	
KY jelly, single use foil pack, 5 grams	31105			31105	6	
tape, VHS	73408			73408	1	
synnige 50 cc & 60 cc	91412			91412	1	
irrgation tube	93402			93402	1	
aquasonic gel (ml)	71001			71001	5ml	
<b>Equipment</b>						
Radiographic/fluoroscopic room	E51005	1		E51005		
film processor, 2 minutes		1			1	
Ultrasound, shimatsu	E52005			E52005	1	

Tab 13 (CVA) - Attachment B  
Comparison Data for Reference and Surveyed Codes

track	CPT	Description	glob	typical pt	EM SAME DAY?	CS?	NF Pre Time	typical pt	EM SAME DAY?	CS OR GA?	FAC Pre Time
L1	36555	Insertion of non-tunneled centrally inserted central venous catheter, under 5 years of age	0	Patient needs short course of IV antibiotics CVL requested and placed same day in the office	NO	CS	C-9	Patient already admitted trauma, needs admin of fluid volume, dehydration or need of calories	YES / MAYBE	CS / GA	0
L2	36556	Insertion of non-tunneled centrally inserted central venous catheter, age 5 years or older	0	Patient to begin dialysis IJ CVL requested Procedure performed same day in office	NO	NO	D-6	Patient already admitted trauma, needs admin of fluid volume, dehydration or need of calories	YES / MAYBE	CS	0
L3	36557	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump, under 5 years of age	10	Patient to begin chemotherapy seen in office and scheduled for procedure on another day patient comes to office on day of procedure	NO	CS	C-9	Patient to begin chemotherapy seen in office and scheduled for procedure on another day admitted on day of procedure as outpatient or possibly overnight if debilitated	NO	CS / GA	A - 26
L4	36558	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump, age 5 years or older	10	Patient to begin chemotherapy seen in office and scheduled for procedure on another day patient comes to office on day of procedure	NO	CS	C-9	Patient to begin chemotherapy seen in office and scheduled for procedure on another day admitted on day of procedure as outpatient or possibly overnight if debilitated	NO	CS	A - 26
L5	36560	Insertion of tunneled centrally inserted central venous access device with subcutaneous port, under 5 years of age	10	Patient to begin chemotherapy seen in office and scheduled for procedure on another day patient comes to office on day of procedure	NO	CS	C-9	Patient to begin chemotherapy seen in office and scheduled for procedure on another day admitted on day of procedure as outpatient or possibly overnight if debilitated	NO	CS / GA	A - 26
L6	36561	Insertion of tunneled centrally inserted central venous access device with subcutaneous port, age 5 years or older	10	Patient to begin chemotherapy seen in office and scheduled for procedure on another day patient comes to office on day of procedure	NO	CS	C-9	Patient to begin chemotherapy seen in office and scheduled for procedure on another day admitted on day of procedure as outpatient or possibly overnight if debilitated	NO	CS	A - 26
L7	36563	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump	10	Patient to begin chemotherapy seen in office and scheduled for procedure on another day patient comes to office on day of procedure	NO	CS	C-9	Patient to begin chemotherapy seen in office and scheduled for procedure on another day admitted on day of procedure as outpatient or possibly overnight if debilitated	NO	CS	A - 26
L8	36565	Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites, without subcutaneous port or pump, (eg, Tesio type catheter).	10	Patient to begin hemodialysis seen in office and scheduled for procedure on another day patient comes to office on day of procedure	NO	CS	C-9	Patient already admitted needs two meds (trauma, dehydration, calories)	YES / MAYBE	CS	0
L9	36566	Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites, with subcutaneous port(s)	10	Patient to begin chemotherapy of two drugs simultaneously seen in office and scheduled for procedure on another day patient comes to office on day of procedure	NO	CS	C-9	Patient to begin chemotherapy of two drugs simultaneously seen in office and scheduled for procedure on another day admitted on day of procedure as outpatient or possibly overnight if debilitated	NO	CS	A - 26
L10	36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, under 5 years of age	0	Patient needs short course of IV antibiotics PICC requested and placed same day in the office	NO	CS	C-9	Patient already admitted, require long term antibiotic therapy children will not generally go home with IV	YES / MAYBE	NO	0
L11	36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, age 5 years or older	0	Patient needs short course of IV antibiotics PICC requested and placed same day in the office	NO	NO	D-6	Patient already admitted, require long term antibiotic therapy - stays in the hospital for awhile and my go home with IV	YES / MAYBE	NO	0
L12	36570	Insertion of peripherally inserted central venous access device with subcutaneous port, under 5 years of age	10	Patient to begin chemotherapy seen in office and scheduled for procedure on another day patient comes to office on day of procedure	NO	CS	C-9	Patient to begin chemotherapy seen in office and scheduled for procedure on another day admitted on day of procedure as outpatient or possibly overnight if debilitated	NO	CS / GA	A - 26
L13	36571	Insertion of peripherally inserted central venous access device with subcutaneous port, age 5 years or older	10	Patient to begin chemotherapy seen in office and scheduled for procedure on another day patient comes to office on day of procedure	NO	CS	C-9	Patient to begin chemotherapy seen in office and scheduled for procedure on another day admitted on day of procedure as outpatient or possibly overnight if debilitated	NO	CS	A - 26
L14	36575	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site	0	Patient presents with catheter leak	YES	NO	0	inpatient if catheter breaks/leaks	YES	NO	0
L15	36576	Repair of central venous access device with subcutaneous port or pump, central or peripheral insertion site	10	A patient presents with a radiologically confirmed leak in a previously placed central venous catheter with subcutaneous port or pump immediately adjacent to the catheter connection to the subcutaneous port/pump	NO	CS	C-9	Repair of central venous access device with subcutaneous port or pump, central or peripheral insertion site	NO	NO	0
L16	36578	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	10	Patient on chemotherapy seen in office and scheduled for replacement on another day	NO	CS	C-9	Patient on chemotherapy seen in office and scheduled for replacement on another day, if problem with catheter admitted on day of procedure as outpatient or possibly overnight if debilitated	NO	CS	A - 26

**Tab 13 (CVA) - Attachment B**  
**Comparison Data for Reference and Surveyed Codes**

track	CPT	Description	glob	typical pt	EM SAME DAY?	CS?	NF Pre Time	typical pt	EM SAME DAY?	CS OR GA?	FAC Pre Time
L17	36580	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	0	Dialysis catheter with poor flow rate TPA failed Pt Comes to the office the day of the procedure	NO	NO	D-6	Dialysis catheter with poor flow rate TPA failed	NO	CS	0
L18	36581	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	10	Dialysis catheter with poor flow rate TPA failed Pt Comes to the office the day of the procedure	NO	CS	C-9	Dialysis catheter with poor flow rate TPA failed	NO	CS	0
L19	36582	Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous port, through same venous access	10	Patient on chemotherapy seen in office and scheduled for replacement on another day	NO	CS	C-9	Patient on chemotherapy seen in office and scheduled for replacement on another day, if problem with catheter admitted on day of procedure as outpatient or possibly overnight if debilitated	NO	CS	A - 26
L20	36583	Replacement, complete, of a tunneled centrally inserted central venous access device with subcutaneous pump, through same venous access	10	Patient on chemotherapy seen in office and scheduled for replacement on another day	NO	CS	C-9	Patient on chemotherapy seen in office and scheduled for replacement on another day, if problem with catheter admitted on day of procedure as outpatient or possibly overnight if debilitated	NO	CS	A - 26
L21	36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access	0	Patient on chemotherapy seen in office and scheduled for replacement on another day	NO	NO	D-6	Patient seen in office and scheduled for replacement on another day, if problem with catheter admitted on day of procedure as outpatient or possibly overnight if debilitated	NO	NO	B - 15
L22	36585	Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access	10	Patient on chemotherapy seen in office and scheduled for replacement on another day	NO	CS	C-9	Patient on chemotherapy seen in office and scheduled for replacement on another day, if problem with catheter admitted on day of procedure as outpatient or possibly overnight if debilitated	NO	CS	A - 26
L23	36589	Removal of tunneled central venous catheter, without subcutaneous port or pump	10	Patient seen in office and scheduled for removal on another day, after conferring with medical oncologist regarding discontinuation of therapy	NO	NO	D - 6	Patient seen in office and scheduled for removal on another day, after conferring with medical oncologist regarding discontinuation of therapy	NO	NO	B - 15
L24	36590	Removal of tunneled central venous access device with subcutaneous port or pump, central or peripheral insertion	10	Patient seen in office and scheduled for removal on another day, after conferring with medical oncologist regarding discontinuation of therapy	NO	CS	C - 9	Patient seen in office and scheduled for removal on another day, after conferring with medical oncologist regarding discontinuation of therapy	NO	CS	B - 15
L29	36597	Repositioning of previously placed central venous catheter under fluoroscopic guidance	0	PICC line noted to be mispositioned in the IJ vein Pt seen in office same day as the procedure	NO	NO	D-6	PICC line noted to be mispositioned in the IJ vein	NO	NO	0

***Non-Facility Pre-time C (with CS; no catheter/port/pump)***

<b>PRE-SERVICE PERIOD</b>	<b>NF</b>	
<b>Total Pre time:</b>	<b>9</b>	
Complete pre-service diagnostic & referral forms	<b>3</b>	One phone call for referral forms
Coordinate pre-surgery services	<b>3</b>	One phone call to Medical Oncologist
Schedule space and equipment in facility	<b>0</b>	No catheter/pump/port
Provide pre-service education/obtain consent	<b>0</b>	Provided on day of procedure.
Follow-up phone calls & prescriptions	<b>3</b>	One phone call: to patient (no food, medicine adjustments, etc prior to admission)

***Non-Facility Pre-time D (no CS; no catheter/port/pump)***

<b>PRE-SERVICE PERIOD</b>	<b>NF</b>	
<b>Total Pre time:</b>	<b>6</b>	
Complete pre-service diagnostic & referral forms	<b>3</b>	One phone call for referral forms
Coordinate pre-surgery services	<b>3</b>	One phone call to Medical Oncologist
Schedule space and equipment in facility	<b>0</b>	No catheter/pump/port
Provide pre-service education/obtain consent	<b>0</b>	Provided on day of procedure.
Follow-up phone calls & prescriptions	<b>0</b>	No special instructions

**Facility Pre-time A (with CS or GA)**

PRE-SERVICE PERIOD	Fac
<b>Total Pre-time:</b>	<b>26</b>
Complete pre-service diagnostic & referral forms	<b>5</b>
Coordinate pre-surgery services	<b>6</b>
Schedule space and equipment in facility	<b>5</b>
Provide pre-service education/obtain consent	<b>7</b>
Follow-up phone calls & prescriptions	<b>3</b>

All standard forms that are ALWAYS necessary to put a patient in a facility for a procedure under IV or general anesthesia (several calls)

Two phone calls PCP and Medical Oncologist (need to discuss type of line/port/pump and coordinate insertion / replacement with drug delivery schedule)

At least 2 phone calls to site (because of need to coordinate with other clinicians - see coord pre-surgery services)

After decision to perform procedure, RN reviews procedure and consent material

One phone call to patient (no food, medicine adjustments, etc prior to admission)

**Facility Pre-time B (No CS or GA)**

PRE-SERVICE PERIOD	Fac
<b>Total Pre-time:</b>	<b>15</b>
Complete pre-service diagnostic & referral forms	<b>3</b>
Coordinate pre-surgery services	<b>3</b>
Schedule space and equipment in facility	<b>3</b>
Provide pre-service education/obtain consent	<b>3</b>
Follow-up phone calls & prescriptions	<b>3</b>

One phone call for referral forms

One phone calls Confer with medical oncologist

One phone call

After decision to perform procedure, RN reviews procedure and consent material

One phone call to patient (no food, medicine adjustments, etc prior to admission)



**Memorandum**

DATE: April 21, 2003  
TO: Sherry Smith  
FROM: Bibb Allen, Jr., MD, ACR RUC Advisor  
Zachary Rattner, MD, SIR RUC Alternate Advisor  
SUBJECT: Cross-Walks to the Non-Physician Work Pool for Codes 75998 and 76937

The American College of Radiology (ACR) and the Society of Interventional Radiology (SIR) recommend that the following codes be added to the non-physician work pool:

- 75998 Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure); and
- 76937 Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure).

In addition, for purposes of cross-walking the new codes to current codes with existing practice expense relative values, we recommend the following:

New Code Number	Cross-Walk Code Number	Cross-Walk Code Descriptor
75998	76003	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device),
76937	76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

Our cross-walk recommendations reflect the fact that codes 76003 and 76942 were those most likely used to describe fluoroscopic and ultrasonic guidance for central venous devices prior to the advent of codes 75998 and 76937.

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Distal Revascularization and Interval Ligation**

After the review of sufficient supportive clinical data, demonstrating both efficacy and safety, the CPT Editorial Panel added one new code to describe the open surgical procedure distal revascularization and interval ligation for the treatment of steal syndrome that occurs in a small proportion of patients who undergo upper extremity hemodialysis access operations.

The new CPT code 36838, *Distal revascularization and interval ligation (DRIL) upper extremity hemodialysis access (steal syndrome)*, (Do not report 36832 in conjunction with 35512, 35522, 36832, 37607, 37618), is a unique operation that is performed on the arm to treat hemodynamic steal syndrome. The specialty society surveyed 31 vascular surgeons, who indicated that the median work value should be 20.00 RVUs. For the new code, respondents indicated a pre-service time of 100 minutes, and intra-service time of 150 minutes, and a post-service time of 161 minutes. The survey respondents selected CPT code 35556, *Bypass graft with vein, femoral-popliteal*, (RVU= 21.76), as a reference service to the new code. However, the selected reference service has a longer intra-service time (200 minutes) and longer post-service times (330 minutes), and is performed on the lower extremity, while the new service with lower intra-service and post-service times, has much higher intensity/complexity values in mental effort and judgment, as well as psychological stress factors, since the patient's hand is at risk. Therefore, the specialty society recommends a work relative value of 20.63, which is equal to the work for new CPT code 35525, *Bypass graft, with vein; brachial-brachial*. The RUC questioned whether the procedure was more difficult than that for a bypass procedure of the vein, brachial-brachial, and the specialty indicated that using a building block analysis the two codes were compared and the time and visits for CPT code 35525 and 36838, were similar in that they both had intensities in the upper range. Given the time and intensity comparisons to and alternate reference code 35525, the RUC determined that specialty societies recommendation was reasonable and accepted the value.

**The RUC recommends a work relative value of 20.63 for CPT code 36838.**

Practice Expense

The RUC accepted the standard 60 minutes for these 90-day facility only procedures. For work related to facility discharge, 12 minutes of clinical staff time was accepted. Standard E/M post-op visit time for clinical staff has been applied for each office visit. Standard supplies and equipment necessary to perform the procedures and for the post-op visit were requested. The practice expense input recommendations are attached.

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

CPT Code (•New)	Track ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●36838	Y1	Distal revascularization and interval ligation (DRIL) upper extremity hemodialysis access (steal syndrome)  (Do not report 36832 in conjunction with 35512, 35522, 36832, 37607, 37618)	090	20.63

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

CPT Code: 36838

Tracking No: Y1

Global: 090

Recommended RVW: 20.63

**Descriptor:** Distal Revascularization and Interval Ligation (DRIL), upper extremity hemodialysis access (steal syndrome)  
(Do not report 36832 in conjunction with 35512, 35522, 36832, 37607, 37618)

---

**SURVEY Vignette (Typical Patient – this information was provided to survey respondents)**

A 65-year-old diabetic with renal failure underwent creation of a brachio-cephalic hemodialysis fistula (CPT 36821) one month ago. She returns with complaint of increasingly severe hand and finger pain. Noninvasive vascular studies confirm hand ischemia with finger pressures <20 mm Hg. The brachio-cephalic fistula is patent and maturing nicely with an excellent palpable thrill in the outflow vein. Further noninvasive and/or arteriographic studies indicate the arterial inflow to the extremity is normal. The diagnosis of hemodialysis access steal syndrome is confirmed. DRIL is recommended.

---

**Clinical Description of Service: (this information was not provided to survey respondents)**

**Pre-service work:**

Pre-service work begins after the decision to operate is made, from the day before the operation until the skin incision. This activity includes obtaining and reviewing the previous work-up, with special attention to potential cardiovascular risk factors. The peripheral vascular exam and preoperative noninvasive and arteriographic studies are reviewed. Informed consent is obtained from the patient following a review of surgical risks and benefits. Discussion is held with the anesthesiologist to determine the anesthetic of choice. Duplex vein mapping studies are reviewed to ensure patient has adequate length and caliber of donor vein conduit for the distal revascularization bypass, and discussions are held with OR nurses regarding appropriate draping to expose all required surgical sites. Other preoperative work includes dressing, scrubbing, supervising patient positioning, waiting for the anesthetic to become effective, prepping, and draping the patient.

**Intra-service work:**

- Incise skin in upper arm overlying proximal portion of brachial artery
- Dissect soft tissue to expose brachial artery, avoid injury to multiple nearby nerves
- Clear soft tissue from brachial for 4 cm length
- Pass soft rubber loops around artery for control
- Incise skin overlying distal brachial artery just beyond elbow
- Dissect soft tissue from around artery, avoid nerve/vein injury
- Pass soft rubber loops around artery for control
- Create a subcutaneous tunnel from proximal to distal incisions
- Prepare vein conduit: Incise skin of thigh/calf over saphenous vein
- Dissect soft tissue to identify saphenous vein
- Clear soft tissue from around saphenous vein for adequate length
- Ligate and divide all saphenous vein branches
- Ligate and divide ends of saphenous vein and remove from lower extremity
- Test saphenous vein conduit for leaks & repair same with 7-0 vascular suture
- Anticoagulate patient with IV heparin
- Apply vascular clamps to site of proximal anastomosis on brachial artery in upper arm
- Perform brachial arteriotomy
- Suture vein conduit to brachial artery with fine vascular suture
- Flush system to remove air and debris & remove clamps to test anastomosis
- Apply additional sutures as needed to control hemorrhage
- Pass vein conduit through tunnel to distal brachial artery site with care to avoid twists/kinks
- Stretch vein to full length
- Apply vascular occluding clamps to distal brachial artery anastomosis site

- Perform arteriotomy
- Cut vein conduit to match length and size of arteriotomy
- Perform most of vein to brachial artery anastomosis with fine vascular suture
- Open clamps briefly to flush out air & debris
- Complete anastomosis
- Remove vascular clamps
- Apply additional sutures to anastomosis as needed to achieve hemostasis
- Listen with Doppler and palpate distal pulses to assure bypass patency
- Isolate a short segment of brachial artery proximal to just-completed distal anastomosis
- Use multiple vascular sutures to ligate brachial artery at this site (= interval ligation)
- Irrigate both brachial artery exposure sites, and the vein donor site
- Close all three incisions in multiple layers
- Recheck pulses to assure patency and hand perfusion prior to application of dressings.

**Post-service work:**

Post-service work begins after skin closure. Tasks include apply dressings, transfer patient to stretcher, accompany patient to recovery area, write orders, dictate operative note, communicate with the patient's family, communicate with referring and consulting physicians, and participate with the anesthesiologist in the recovery area to ensure smooth emergence from anesthesia. Results of the procedure are discussed with the patient once he or she is fully awake. The patient is transferred to the acute care ward when criteria for discharge from recovery area are met.

The physician makes daily hospital inpatient visits and takes interval history. Physical exam includes examining bypass graft for patency, examining hand for adequate perfusion/function, and examining all surgical incisions. Physician makes assessment and plan, writes orders & notes, communicates with patient, family, nurses, and other caregivers. Discharge day management includes communicating with all support services such as visiting nurse, meals on wheels, etc., communicating with referring physician, providing activity advice and warnings to patient and family, and arranging office follow-up for wound checks, suture/staple removal, etc. All related post-discharge care for 90-days is included in this service.

---

**SURVEY DATA**

<b>Presenters:</b>	Gary Seabrook, M.D., and Robert Zwolak, M.D.					
<b>Specialty:</b>	American Association for Vascular Surgery					
<b>CPT Code:</b>	36838					
<b>Sample Size:</b>	200	<b>Resp n:</b>	31	<b>Resp %:</b>	16%	
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		15.00	18.00	20.00	23.25	28.00
<b>Pre-Service Evaluation Time:</b>				65		
<b>Pre-Service Positioning Time:</b>				15		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				20		
<b>Intra-Service Time:</b>		100	120	150	169	200
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	30					
<b>Critical Care time/visit(s):</b>	0					
<b>Other Hospital time/visit(s):</b>	49	99232 x1, 99231 x1				
<b>Discharge Day Mgmt:</b>	36	99238				
<b>Office time/visit(s):</b>	46	99213 x 2				

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

CPT	Descriptor	'03 RVW	Glob
35556	Bypass graft with vein, femoral-popliteal	21.76	090

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE:**

	Svy CPT 36838	Ref CPT 35556
<b>TIME ESTIMATES (MEDIAN)</b>		
Pre-service	100	90
Intra-service	150	200
Same Day Immediate Post-service	30	40
Critical care	0	0
Other hospital visit	49	201
Discharge day management	36	36
Office visit	46	53
<i>TOTAL TIME</i>	<i>411</i>	<i>620</i>
<b>INTENSITY/COMPLEXITY MEASURES (mean)</b>		
Reference survey response count	10	10
<b>TIME SEGMENTS</b>		
Pre-service	3.70	3.30
Intra-service	4.00	4.10
Post-service	3.10	3.10
<b>MENTAL EFFORT AND JUDGMENT</b>		
The number of possible diagnosis and/or the number of management options that must be considered	3.80	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	3.56
Urgency of medical decision making	4.50	3.56
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>		
Technical skill required	4.30	4.22
Physical effort required	3.40	3.67
<b>PSYCHOLOGICAL STRESS</b>		
The risk of significant complications, morbidity and/or mortality	4.00	4.11
Outcome depends on the skill and judgment of physician	4.30	4.11
Estimated risk of malpractice suit with poor outcome	4.50	4.22

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

**We recommend an RVW of 20.63 for this service based primarily on data from sections 2 & 3 on page 6.**

DRIL is a unique operation, and there was no clinically similar service on the reference list. The most frequency chosen reference was a bypass graft performed with vein conduit, CPT 35556. 35556 is performed on the lower extremity for arterial occlusive disease, while DRIL is performed on the arm for hemodynamic steal syndrome. 35556 has a longer intra-time and a longer hospital stay, while the new service has much higher intensity/complexity values in mental effort and judgment as well as psychological stress factors. Urgency of decision making is extremely high for the new service because viability of the patient's hand is at risk. We believe this comparison indicates that the new service should have a lower RVW than the reference 35556, but the two services are so different it is difficult to be more exact. We believe the IWPUT on next page helps show why 35556 is not a solid reference service, while items 2 and 3 on page 6 & 7 really help nail down 20.63 as a fair RVW for this service.

**ADDITIONAL RATIONALE**

*If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**1. IWPUT analysis**

The following building block analysis compares the time and visit pattern of the new code to the reference service 35556. Time and visits are *not* similar. The calculated IWPUT of 0.092 for the new service puts it in the range of upper extremity bypass grafts, as noted in the table on next page. This IWPUT for the new service is exactly that of 35525, brachial-brachial bypass, with vein, and that is appropriate since 35525 is an extremely similar clinical service.

IWPUT calculation for the reference (0.048) is an extremely low value for a bypass graft constructed with vein conduit, and it helps explain why survey respondents felt the RVW for the new service should be only a small amount less than 35556 rather than substantially less.

ROW / COLUMN	A	B	C	D	E	F
1	36838	MFS RVW:	20.63	35556	MFS RVW:	21.76
2	Svy Data	RUC Std.	RVW	Svy Data	RUC Std.	RVW
3	<b>Pre-service:</b>	Time	Intensity (=time x ints'y)	Time	Intensity (=time x ints'y)	
4	Pre: eval & posit	80	0.0224	1.79	60	0.0224
5	Pre: scrub,dress,wait	20	0.0081	0.16	30	0.0081
6	<b>Pre-service total</b>		1.95			
7	<b>Post-service:</b>	Time	Intensity (=time x ints'y)	Time	Intensity (=time x ints'y)	
8	Immediate post	30	0.0224	0.67	40	0.0224
9	<b>Subsequent visits:</b>	Visit n	E/M RVW (=n x RVW)	Visit n	E/M RVW (=n x RVW)	
10	ICU 99291		4.00			4.00
11	99233		1.51			1.51
12	99232	1	1.06	1.06	1	1.06
13	99231	1	0.64	0.64	9	0.64
14	Discharge 99238	1	1.28	1.28	1	1.28
15	Discharge 99239		1.75			1.75
16	99215		1.73			1.73
17	99214		1.08			1.08
18	99213	2	0.65	1.30	1	0.65
19	99212		0.43		2	0.43
20	99211		0.17			0.17
21	<b>Post-service total</b>		4.95			10.51
22	<b>Intra-service:</b>	Time	IWPUT	INTRA-RVW	Time	IWPUT
23	<b>Intra total</b>	150	0.092	13.72	200	0.048

## 2. What in the world is a “DRIL”?

Although physiologic considerations behind the DRIL are complex, the operation is simple to think of in terms of surgical procedure based on CPT codes. In essence, the typical DRIL is a short brachial-brachial bypass performed with vein conduit (eg CPT 35525: Brachial-brachial bypass with vein), plus ligation of the native brachial artery (eg CPT 37618: Ligation, major artery; extremity).

If we had not requested a specific CPT code for DRIL it would have been coded and valued as the combination of these two codes:

CPT code	Shortened Descriptor	RVW	Global	Intra-time	Payment Rules
35525	Brachial-brachial bypass with vein conduit	20.63 proposed	090	150	20.63, full payment
37618	Ligation, major artery extremity	4.84 2 <sup>nd</sup> 5 yr	090	73	2.42, mult. procedure reduction
<b>Total</b>	<b>2 Codes</b>			223	<b>23.05</b>

The typical patient undergoing DRIL has a bypass graft that is slightly shorter in length than the typical 35525. The time required to ligate and divide the brachial artery is shorter during DRIL than the 73 minutes of intra-time for the typical 37618. Considered overall, respondents felt the total intra-time for DRIL (150 minutes) was exactly the same as the total intra-time for 35525.

### 3. Comparison within the closest clinical family of procedures indicates appropriate “relative” value.

The main component of the typical DRIL operation is performance of a brachial-brachial bypass graft with vein conduit. Thus, CPT 35525 and the family table used earlier in this April 2003 RUC meeting (for Tab 12, 35510 – 35525) constitutes suitable reference data.

We believe that 36838 should not have a lower RVW than 35525 because the former contains the latter as one of its two components. **In order to prevent a rank order anomaly we recommend an RVW of 20.63 for 36838.**

CPT	Short Descriptor	RVW	Source	Intra-Time	IWPUT
<b>36838</b>	<b>Distal Revascularization Interval Ligation DRIL</b>	<b>20.63 proposed</b>	<b>Current Proposal</b>	<b>150</b>	<b>0.092</b>
35525	Bypass graft with vein, brachial-brachial	20.63 proposed	Current Proposal	150	0.092
35511	Bypass graft with vein, subclavian-subclavian	21.20	Second 5-Yr review	150	0.097
35518	Bypass graft with vein, Axillary-axillary	21.20	Second 5-Yr review	140	0.094
35558	Bypass graft with vein, Femoral-femoral	21.20	Second 5-Yr review	180	0.067
35556	Bypass graft with vein, Femoral-popliteal	21.76	First 5-Yr review	200	0.048
35522	Bypass graft with vein, Axillary-brachial	21.76 proposed	Current Proposal	180	0.077
35521	Bypass graft with vein, Axillary-femoral	22.20	Second 5-Yr review	155	0.082
35512	Bypass graft with vein, Subclavian-brachial	22.50 proposed	Current Proposal	180	0.081
35510	Bypass graft with vein, Carotid-brachial	23.00 proposed	Current Proposal	180	0.087
35565	Bypass graft with vein, Ilio-femoral	23.20	Second 5-Yr review	180	0.078
35571	Bypass graft with vein, Popliteal-tibial	24.06	Second 5-Yr review	180	0.086
35533	Bypass graft with vein, Axillary-bifemoral	28.00	Second 5-Yr review	240	0.077
35526	Bypass graft with vein, Aorto-subclavian	29.95	Second 5-Yr review	210	0.100

**Services Reported with Multiple CPT Codes**

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

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

	The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
X	Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
X	Multiple codes allow flexibility to describe exactly what components the procedure included.
	Multiple codes are used to maintain consistency with similar codes.
	Historical precedents.
X	Other reason (please explain): In high % of cases only the primary procedure is performed and coded. Many surgeons do not perform any reportable additional maneuvers to evaluate technical adequacy of a bypass graft.

In many or most cases this procedure will not be reported with other CPT codes. The issue surrounds how a vascular surgeon evaluates the technical adequacy of a bypass graft before leaving the OR. Some surgeons simply palpate the graft pulse and distal pulses in the limb, and if present, they are satisfied. Other surgeons will listen to the bypass graft with a handheld Doppler, and that is not reportable with any additional codes. Smaller subsets will undertake completion studies using a duplex scan, a completion angiogram, or an angioscopy examination. These latter three procedures are separately reportable.

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

**Methods to assess technical adequacy of a new bypass graft in the OR, from low to high tech:**

Method	CPT Code	Global	RVW	Intra-time
Palpate pulses	None	None	None	<5 minutes
Handheld Doppler	None	None	None	<5 minutes
Intra-op Duplex scan	93931-26	XXX	0.31	13 minutes
Completion arteriogram	75710-26	XXX	1.14	22 minutes
Angioscopy	35400	ZZZ	3.00	45 minutes

**FREQUENCY INFORMATION**

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

37799, Unlisted procedure, vascular surgery

**How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Vascular Surgery, General Surgery, Transplant Surgery      ~~Commonly~~      Sometimes      Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Vascular Surgery, General Surgery, Transplant Surgery      Frequency: less than 1,000

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

Specialty: Vascular Surgery, General Surgery, Transplant Surgery      Frequency: Since virtually all hemodialysis patients in U.S. are covered by Medicare, the total frequency of this operation will equal the Medicare frequency. We estimate <1,000 per year.

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

---

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
090 Day Global Period  
Facility Direct Inputs**

<b>CPT</b>	<b>DESCRIPTION</b>	<b>GLOBAL</b>
36838	Distal Revascularization and Interval Ligation (DRIL), upper extremity hemodialysis access (steal syndrome)	90

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:** The direct practice expense details were developed by physicians from the American Association of Vascular Surgeons representing a broad mix of categories of type of practice and geographic areas.

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time (prior to admission):** For each of these 90-day facility only procedures, the standard "typical" 60 minutes have been applied.

**Service period clinical staff time (admission to discharge):**

Pre-service: N/A

Intra-service: N/A

Post-service: 12 minutes of clinical staff time for work related to facility discharge.

**Post-service period clinical staff time:** Standard EM postop visit time for clinical staff has been applied for each office visit.

**SUPPLIES AND EQUIPMENT:**

Minimal supplies and equipment necessary to perform the procedures and for post op visit supplies are presented.

---

36838 PE Details (April 2003 RUC)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	36838	
		Distal Revascularization and "Interval Ligation" (DRIL), upper extremity hemodialysis access (steal syndrome)	
GLOBAL PERIOD		90	
LOCATION		NonFac	Fac
TOTAL CLINICAL LABOR TIME	1130	N/A	144
PRE-SERVICE PERIOD TOTAL TIME	1130		60
SERVICE PERIOD TOTAL TIME	1130		12
POST-SERVICE PERIOD TIME	1130		72
<b>PRE-SERVICE PERIOD</b>			
Complete pre-service diagnostic & referral forms	1130		5
Coordinate pre-surgery services	1130		20
Schedule space and equipment in facility	1130		8
Provide pre-service education/obtain consent	1130		20
Follow-up phone calls & prescriptions	1130		7
Other Clinical Activity (please specify)			
<b>SERVICE PERIOD</b>			
Pre-service			0
Intra-service			0
Post-Service			
Discharge day management 99238 –12 minutes 99239 –15 minutes	1130		12
Other Clinical Activity (please specify)			
<b>POST-SERVICE PERIOD</b>			
Conduct phone calls/call in prescriptions			
<i>List Number and Level of Office Visits</i>			
99211 16 minutes			
99212 27 minutes			
99213 36 minutes			2
99214 53 minutes			
99215 63 minutes			
<b>Total Office Visit Time</b>	1130	0	72
Other Activity (please specify)			
<b>MEDICAL SUPPLIES</b>			
minimum visit package (multispecialty)	PEAC pack		2
post-op incision care kit	PEAC kit		1
<b>Equipment</b>			
exam table	E11001		1
exam lamp	E30006		1

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Varicose Vein Stab Phlebectomy**

The CPT Editorial Panel created two new codes and revised one existing code to describe new open surgical procedures to treat symptomatic varicose veins.

CPT code 37765 and 37766

The specialty society surveyed 41 vascular surgeons for new CPT code 37765 with the following description, *Stab phlebectomy of varicose veins, one extremity; up to 20 stab incisions*, and determined a median RVW of 11.00. During the review of the new codes, the specialty society became aware that the recommended work RVUs may be too high. Therefore, the specialty society provided a new recommendation based on IWPUT and the building block approach. Survey respondents indicated an intra-service time of 60 minutes, a pre-service time of 58 minutes, and a post-service time of 81 minutes. The presenters analyzed intensity of the vein excision codes 37700, 37720, 37730, 37780, and 37785 which yielded a range of intensities between 0.063 to 0.070, and determined that the midpoint of 0.066 could be used as an accurate comparison to the new code. This intensity of 0.66 was multiplied by the surveyed intra-service time of 60 minutes. The standard building block method was then used to revised the recommended RVU to 7.35, which placed the code in proper rank order to the vein excision codes. The typical patient is 10-15 incisions, the original CPT proposal recommended a code for up to 15 incision, a code for 16-30 incisions, and more than 30 incisions. The RUC asked the specialty society to work with the CPT Editorial Panel to clarify the wording for these codes by modifying the description to indicate 10-20 incisions. The RUC also requested the addition of a parenthetical note to state for less than 10 incisions, use the unlisted code 37799. The CPT Editorial Panel has modified the nomenclature for CPT 2004 to read, *Stab phlebectomy of varicose veins, one extremity; 10 – 20 stab incisions (For less than 10 use 37999) (For more than 20 incisions, use 37766)*.

Similarly, for CPT code 37766, *Stab phlebectomy of varicose veins, one extremity; more than 20 incisions*, the presenters used the 0.066 midpoint intensity and building block approach to revise the work relative value determined by the survey respondents. The survey respondents indicated a pre-service time of 58 minutes, an intra-service time of 90 minutes, and a post-service time of 81 minutes. The intra-service time of 90 minutes was multiplied by the midpoint intensity for vein excision codes of 0.066. A building block method was then used to include the pre- and post-service times. This process resulted in a final RVU of 9.30, a decrease from the originally proposed RVU of 11.00. The RUC agreed that the new values better reflected work for the typical patient, requiring between 10-15 incisions and also placed the code in proper rank order, in comparison to the vein excision codes.

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

The RUC recommends a relative work value of 7.35 for CPT code 37765 and a relative work value of 9.30 for CPT code 37766.

CPT code 37785

The specialty society is in the process of submitting a code change proposal request to CPT for existing code 37785 that will address various issues, including the “recurrent” issue and will survey the code after the nomenclature has been revised.

Practice Expense

The practice expense inputs were accepted as submitted, and are attached to this recommendation.

CPT Code (●New)	Track ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●37765	Z1	Stab phlebectomy of varicose veins, one extremity; 10 – 20 stab incisions  (For less than 10 use 37999)  (For more than 20 incisions, use 37766)	090	7.35
●37766	Z2	more than 20 incisions	090	9.30
▲37785	Z3	Ligation, division, and/or excision of recurrent or secondary varicose veins (cluster(s)), one leg  (37787 has been deleted. To report, use 37785 with modifier ‘-50’)	090	3.84  (no change)

CPT Code: 37765

Tracking No: Z1Global: 090

RUC Recommended RVW: 7.35

**Descriptor:** Stab phlebectomy of varicose veins, one extremity; 10 – 20 stab incisions, (For less than 10 use 37999) (For more than 20 incisions, use 37766)

**SURVEY Vignette (Typical Patient – this information supplied to survey respondents)**

A 70-year-old man with a lifelong history of slowly enlarging left lower extremity varicose veins complains of pain and heaviness in the leg when trying to participate in the daily exercise routine recommended by his PCP. He has failed a trial of medical-grade graduated compression stockings. Stab phlebectomy is performed.

**Clinical Description of Service: (this information was not provided to survey respondents)**

**Pre-service work:**

Pre-service work begins after the decision to operate is made, from the day before the operation until the skin incision. This activity includes obtaining and reviewing the previous work-up, with special attention to potential cardiovascular risk factors. The peripheral vascular exam and the preoperative noninvasive studies are reviewed. Informed consent, citing potential risks, is reviewed for the final time with patient and family. Discussion is held with the anesthesiologist to determine the anesthetic of choice. A discussion is held with OR nurses regarding appropriate draping to expose all symptomatic veins. Unique to stab phlebectomy is the vein marking that must be performed immediately before the operation. Since even very large varicosities collapse when a patient is supine, the target veins must be marked with the patient erect. This is typically performed with the patient on a small pedestal in the pre-operative holding area. The surgeon uses a large magic marker, or “Sharpie,” placing a mark over each varicosity that will be excised. Each vein is marked individually in what oftentimes looks like a topographical map when completed. Other routine preoperative work includes dressing, scrubbing, supervising patient positioning, waiting for the anesthetic to become effective, prepping, and draping the patient.

**Intra-service work:**

- Incise skin over one of the marked veins using a very small scalpel blade
- This is oftentimes performed by surgeon wearing optical magnifying “loupes”
- Gently dissect subcutaneous tissue to find vein
- Pass instrument or “crochet hook” around vein
- Using gentle traction and twisting motion, extract vein through skin incision
- Use Kitner or other soft pad instrument to bluntly dissect soft tissue from vein
- Evert as much vein as possible through incision
- Perform final phlebectomy of everted vein with a snapping motion
- Hold pressure over phlebectomy site
- When hemostasis is achieved move to next site.
- Close incisions with a single subcuticular dissolving suture or a steri-strip
- Repeat up to 20 x individual skin incisions

**Post-service work:**

Post-service work begins after skin closure. Tasks include apply dressings, transfer patient to stretcher, accompany patient to recovery area, write orders, dictate operative note, communicate with the patient’s family, communicate with referring and consulting physicians, and participate with the anesthesiologist in the recovery area to ensure smooth emergence from anesthesia. Results of the procedure are discussed with the patient once he or she is fully awake. This service is most often performed as a “same-day” surgery. Discharge management takes place once the anesthetic has resolved completely, and includes providing activity advice and warnings to patient and family, and arranging office follow-up for wound checks, etc. All related post-discharge care for remainder of the global period (90 days) is included in this service.

**SURVEY DATA**

<b>Presenters:</b>	Gary Seabrook, M.D., Robert Zwolak, M.D.					
<b>Specialty:</b>	American Association for Vascular Surgery					
<b>CPT Code:</b>	37765					
<b>Sample Size:</b>	200	<b>Resp n:</b>	41	<b>Resp %:</b>	21%	
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		7.80	9.00	11.00	12.00	19.00
<b>Pre-Service Evaluation Time:</b>				33		
<b>Pre-Service Positioning Time:</b>				10		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				15		
<b>Intra-Service Time:</b>				60		
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	25					
<b>Critical Care time/visit(s):</b>	0					
<b>Other Hospital time/visit(s):</b>	0					
<b>Discharge Day Mgmt:</b>	18	99238 x ½				
<b>Office time/visit(s):</b>	38	99213 x1, 99212 x1				

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**Note:** 9 survey respondents noted that their typical patient is younger than the vignette patient, and female.

**KEY REFERENCE SERVICE:**

CPT	Descriptor	'03 RVW	Glob
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	11.00	090

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE:**

	Svy CPT 37765	Ref CPT 37500
<b>TIME ESTIMATES (MEDIAN)</b>		
Pre-service	58	90
Intra-service	60	90
Same Day Immediate Post-service	25	30
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	18
Office visit	38	61
<i>TOTAL TIME</i>	<i>199</i>	<i>289</i>
<b>INTENSITY/COMPLEXITY MEASURES (mean)</b>		
Intensity comparison survey count	13	13
<b>TIME SEGMENTS</b>		
Pre-service	1.92	2.31
Intra-service	2.31	2.62
Post-service	1.77	2.08
<b>MENTAL EFFORT AND JUDGMENT</b>		
The number of possible diagnosis and/or the number of management options that must be considered	2.08	2.46
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.08	2.38
Urgency of medical decision making	1.31	1.38
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>		
Technical skill required	2.23	2.23
Physical effort required	2.23	2.31
<b>PSYCHOLOGICAL STRESS</b>		
The risk of significant complications, morbidity and/or mortality	1.69	2.08
Outcome depends on the skill and judgment of physician	2.08	2.54
Estimated risk of malpractice suit with poor outcome	2.08	2.23

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

**We recommend the 25<sup>th</sup> percentile survey response, an RVW of 9.0, based on a comparison to the reference service plus additional rationale data presented on page 5.**

Stab phlebectomy of varicose veins is a unique new service, and there were no similar services, from a clinical perspective, on the vascular surgery reference list. A laparoscopic operation to treat incompetent perforator veins was chosen for comparison (CPT 37500, RVW 11.00). The new service has 32 minutes less pre-time, 30 minutes less intra-time, and 28 minutes less post-time than the reference. Most intensity and complexity measures for the new service were less than corresponding values for the reference service. Review of these data suggests that the new service RVW should be less than the median survey value of 11.00.

## ADDITIONAL RATIONALE

If your society has used an IWPOT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.

### 1. IWPOT Analysis:

The following building block analysis compares the time and visit pattern of the new code to the reference service 37500. Time and visits are reasonably similar. Using the 25<sup>th</sup> percentile RVW of 9.00, the new service calculated IWPOT is 0.094. The reference has an IWPOT of 0.068. Conclusion from this exercise is that new service RVW should not be more than 25<sup>th</sup> percentile.

ROW / COLUMN	A	B	C	D	E	F
1	37765	MFS RVW:	9.00	37500	MFS RVW:	11.00
2	Svy Data	RUC Std.	RVW	Svy Data	RUC Std.	RVW
3	<b>Pre-service:</b>	Time	Intensity (=time x ints'y)	Time	Intensity (=time x ints'y)	
4	Pre: eval & posit	43	0.0224	0.96	80	0.0224
5	Pre: scrub,dress,wait	15	0.0081	0.12	10	0.0081
6	<b>Pre-service total</b>		1.08			1.87
7	<b>Post-service:</b>	Time	Intensity (=time x ints'y)	Time	Intensity (=time x ints'y)	
8	Immediate post	25	0.0224	0.56	30	0.0224
9	<b>Subsequent visits:</b>	Visit n	E/M RVW (=n x RVW)	Visit n	E/M RVW (=n x RVW)	
10	ICU 99291		4.00			4.00
11	99233		1.51			1.51
12	99232		1.06			1.06
13	99231		0.64			0.64
14	Discharge 99238	0.5	1.28	0.64	0.5	1.28
15	Discharge 99239		1.75			1.75
16	99215		1.73			1.73
17	99214		1.08			1.08
18	99213	1	0.65	0.65	2	0.65
19	99212	1	0.43	0.43	1	0.43
20	99211		0.17			0.17
21	<b>Post-service total</b>		2.28			3.04
22	<b>Intra-service:</b>	Time	IWPOT	INTRA-RVW	Time	IWPOT
23	<b>Intra total</b>	60	0.094	5.64	90	0.068

## 2. Comparison with services with similar RVW, intra-time and total-time

Since there are no clinically similar vascular surgery services for comparison we searched the RUC database for procedures with time values that match our survey data and RVWs that match our recommendation. Specifically, the search parameters were  $RVW \geq 9.00$  *and* intra-time of  $\leq 60$  minutes, *and* total time of  $\leq 199$  minutes. These search criteria provided a list of all services that are valued at or higher than our recommendation, with intra and total times the same or less than our new service. There are 26 such services across a wide variety of specialties, including two procedures that provide grounds for a clinical comparison (see table below).

The two closest services on this table from a clinical perspective are CPT 17107 and 17108, Destruction of cutaneous vascular proliferative lesions. These two services underwent RUC analysis in 1995. Both are 90-day globals with RVWs greater than our new service recommendation of 9.0. Both comparison services have intra-times less than the 60 minutes of our new service (17107 has 30 min intra, 17108 has 45 min intra). In addition, both services have total time significantly less than the 199 minutes of our new service (17107 has 80 min intra, 17108 has 95 min intra). Thus, these two vascular ablation procedures have higher RVWs for less time than we are recommending for 37765

Based on this comparison with clinical services that also deal with vascular lesions, and in light of fact that these services have higher RVWs but less intra and total time, we believe the 25<sup>th</sup> percentile RVW of 9.0 is appropriate for the new service 37765.

RUC Database Services with RVW >9.0, Intra time <60, and Total time <199 minutes Sorted in order of increasing RVW Proposed service and best clinical comparisons are in Bold							
CPT	Descriptor	RVW	Global	Time source	Intra time	Total time	RUC meeting date
<b>37765</b>	<b>Stab phlebectomy of varicose veins, one extremity; up to and including 20 incisions</b>	<b>9.00 proposed</b>	090	RUC survey	60	199	RUC April 2003
66850	Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration	9.11	090	Harvard	44	189	Aug95
<b>17107</b>	<b>Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 - 50.0 sq cm</b>	<b>9.16</b>	<b>090</b>	<b>RUC</b>	<b>30</b>	<b>80</b>	<b>Aug95</b>
15839	Excision, excessive skin and subcutaneous tissue (including lipectomy); other area	9.38	090	Harvard	43	199	
22850	Removal of posterior nonsegmental instrumentation (eg, Harrington rod)	9.52	090	Harvard	60	199	
69676	Tympanic neurectomy	9.52	090	Harvard	58	171	
49520	Repair recurrent inguinal hernia, any age; reducible	9.63	090	RUC	60	183.5	August 2000
69650	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair), Stapes mobilization	9.66	090	Harvard	51	160	
45190	Destruction of rectal tumor (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach	9.74	090	Harvard	0	167	May94
69666	Repair oval window fistula	9.75	090	Harvard	57	174	
69667	Repair round window fistula	9.76	090	Harvard	57	169	
61609	Transection or ligation, carotid artery in cavernous sinus; without repair (List separately in addition to code for primary procedure)	9.89	ZZZ	Harvard	0	157	Jan93
61609	Transection or ligation, carotid artery in cavernous sinus; without repair (List separately in addition to code for primary procedure)	9.89	ZZZ	Harvard	0	157	Jan93
66852	Removal of lens material; pars plana approach, with or without vitrectomy	9.97	090	Harvard	48	193	Aug95

23430	Tenodesis of long tendon of biceps	9.98	090	Harvard	60	199	Editorial
44950	Appendectomy;	10	090	Harvard	37	175	Aug95
66930	Removal of lens material, intracapsular, for dislocated lens	10.18	090	Harvard	47	192	Aug95
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)	10.23	090	RUC	50	190	Aug95
65850	Trabeculectomy ab externo	10.52	090	Harvard	44	160	
37565	Ligation, internal jugular vein	10.88	090	Harvard	42	177	Editorial
58920	Wedge resection or bisection of ovary, unilateral or bilateral	11.36	090	Harvard	53	178	August 2000
54650	Orchiopexy, abdominal approach, for intra-abdominal testis (eg, Fowler-Stephens)	11.45	090	Harvard	0	199	Apr93
45170	Excision of rectal tumor, transanal approach	11.49	090	Harvard	57	198	
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	11.67	090	Harvard	58	199	August 2000
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminae wiring at C1, facet screw fixation)	12.54	ZZZ	RUC	60	60	Apr95
67220	Destruction of localized lesion of choroid (eg, choroidal neovascularization), photocoagulation (eg, laser), one or more sessions	13.13	090	RUC	25	152	May98
17108	<b>Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm</b>	<b>13.2</b>	<b>090</b>	<b>RUC</b>	<b>45</b>	<b>95</b>	<b>Aug95</b>

### Services Reported with Multiple CPT Codes

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

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

**As noted in our CPT application, this service will be reported by itself in a substantial proportion of cases. At other times it will be reported with services that treat incompetent greater or lesser saphenous vein, such as 37700, 37720, 37730, or 37735.**

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

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

**The following table presents the new code along with the procedure that is most likely to be reported simultaneously in situations when the new procedure is reported with multiple codes**

CPT	Shortened Descriptor	Global	RVW	Mult Procedure Reduction	Pre Time	Intra Time	Post time
37765	Stab phlebectomy	090	9.00	9.00	58	60	81
37720	Ligation and division and complete stripping of long or short saphenous vein	090	5.66	2.83	27 Hvd	83 Hvd	102 Hvd
<b>Total</b>				<b>11.83</b>		<b>143</b>	

**FREQUENCY INFORMATION**

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

37799 Unlisted procedure, vascular surgery

**How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Vascular Surgery, Plastic Surgery, General Surgery      Commonly      Sometimes      Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Vascular Surgery, Plastic Surgery, General Surgery      Frequency: 4,500

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

Specialty: Vascular Surgery, Plastic Surgery, General Surgery      Frequency: 2,500

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

---

CPT Code: 37766

Tracking No: Z2

Global: 090

RUC Recommended RVW: 9.30

**Descriptor:** Stab phlebectomy of varicose veins, one extremity; more than 20 incisions

---

**SURVEY Vignette (Typical Patient – this information supplied to survey respondents)**

A 70-year-old man with a lifelong history of slowly enlarging left lower extremity varicose veins complains of pain and heaviness in the leg when trying to participate in the daily exercise routine recommended by his PCP. He has failed a trial of medical-grade graduated compression stockings. Stab phlebectomy is performed

*Note: This is same patient as 37765 except that he has more veins requiring treatment.*

---

**Clinical Description of Service: (this information was not provided to survey respondents)**

**Pre-service work:**

Pre-service work begins after the decision to operate is made, from the day before the operation until the skin incision. This activity includes obtaining and reviewing the previous work-up, with special attention to potential cardiovascular risk factors. The peripheral vascular exam and the preoperative noninvasive studies are reviewed. Informed consent, citing potential risks, is reviewed for the final time with patient and family. Discussion is held with the anesthesiologist to determine the anesthetic of choice. Discussions are held with OR nurses regarding appropriate draping to expose all symptomatic veins. Unique to stab phlebectomy is the vein marking that must be performed immediately before the operation. Since even very large varicosities collapse when a patient is supine, the target veins must be marked with the patient erect. This is typically performed with the patient on a small pedestal in the pre-operative holding area. The surgeon uses a large magic marker, or "Sharpie," placing a mark over each varicosity that will be excised. Each vein is marked individually in what oftentimes looks like a topographical map when completed. Other routine preoperative work includes dressing, scrubbing, supervising patient positioning, waiting for the anesthetic to become effective, prepping, and draping the patient.

**Intra-service work:**

- Incise skin over one of the marked veins using a very small scalpel blade
- This is oftentimes performed by surgeon wearing optical magnifying "loupes"
- Gently dissect subcutaneous tissue to find vein
- Pass instrument or "crochet hook" around vein
- Using gentle traction and twisting motion, extract vein through skin incision
- Use Kitner or other soft pad instrument to bluntly dissect soft tissue from vein
- Evert as much vein as possible through incision
- Perform final phlebectomy of everted vein with a snapping motion
- Hold pressure over phlebectomy site
- When hemostasis is achieved move to next site.
- Close incisions with a single subcuticular dissolving suture or a steri-strip
- Repeat 21+ individual skin incisions

**Post-service work:**

Post-service work begins after skin closure. Tasks include apply dressings, transfer patient to stretcher, accompany patient to recovery area, write orders, dictate operative note, communicate with the patient's family, communicate with referring and consulting physicians, and participate with the anesthesiologist in the recovery area to ensure smooth emergence from anesthesia. Results of the procedure are discussed with the patient once he or she is fully awake. This service is most often performed as a "same-day" surgery. Discharge management takes place once the anesthetic has resolved completely, and includes providing activity advice and warnings to

patient and family, and arranging office follow-up for wound checks, etc. All related post-discharge care for remainder of the global period (90 days) is included in this service.

### SURVEY DATA

<b>Presenters:</b>	Gary Seabrook, M.D., Robert Zwolak, M.D.					
<b>Specialty:</b>	American Association for Vascular Surgery					
<b>CPT Code:</b>	37766					
<b>Sample Size:</b>	200	<b>Resp n:</b>	41	<b>Resp %:</b>	21%	
<b>Sample Type:</b> Random						
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		8.00	11.00	13.00	14.00	20.00
<b>Pre-Service Evaluation Time:</b>				33		
<b>Pre-Service Positioning Time:</b>				10		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				15		
<b>Intra-Service Time:</b>		70	90	90	120	210
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	25					
<b>Critical Care time/visit(s):</b>	0					
<b>Other Hospital time/visit(s):</b>	0					
<b>Discharge Day Mgmt:</b>	18	99238 x 0.5				
<b>Office time/visit(s):</b>	38	99213 x 1, 99212 x 1				

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**Note:** 9 survey respondents noted that their typical patient is younger than the vignette patient.

**KEY REFERENCE SERVICE:**

CPT	Descriptor	'03 RVW	Glob
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	11.00	090

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE:**

	Svy CPT 37766	Ref CPT 37500
<b>TIME ESTIMATES (MEDIAN)</b>		
Pre-service	58	90
Intra-service	90	90
Same Day Immediate Post-service	25	30
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	18
Office visit	38	61
<i>TOTAL TIME</i>	229	289

**INTENSITY/COMPLEXITY MEASURES (mean)**

Intensity comparison survey count 13 13

**TIME SEGMENTS**

Pre-service	2.14	2.57
Intra-service	2.43	2.79
Post-service	1.93	2.21

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	2.00	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.14	2.50
Urgency of medical decision making	1.50	1.57

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	2.21	3.14
Physical effort required	2.50	2.50

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	1.86	2.29
Outcome depends on the skill and judgment of physician	2.29	2.79
Estimated risk of malpractice suit with poor outcome	2.29	2.50

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

We recommend the 25<sup>th</sup> percentile survey response, an RVW of 11.0, based on a comparison to the reference service plus additional rationale data presented on pages 5 & 6.

Stab phlebectomy of varicose veins is a unique new service, and there were no similar services, from a clinical perspective, on the vascular surgery reference list. A laparoscopic operation to treat incompetent perforator veins was chosen for comparison (CPT 37500, RVW 11.00). The new service has 32 minutes less pre-time, exactly the same intra-time, and 28 minutes less post-time than the reference. Most intensity and complexity measures for the new service were slightly less than corresponding values for the reference. Review of these data suggests that the new service RVW should be less than the median survey value of 13.00.

## ADDITIONAL RATIONALE

If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.

### 1. IWPUT Analysis:

The following building block analysis compares the time and visit pattern of the new code to the reference service 37500. Time and visits are reasonably similar. Using our recommended 25<sup>th</sup> percentile RVW of 11.00, the new service calculated IWPUT is 0.085. The reference has an IWPUT of 0.068. Conclusion from this exercise is that new service RVW should not be more than 25<sup>th</sup> percentile.

ROW / COLUMN	A	B	C	D	E	F	
1	37766	MFS RVW:	9.00	37500	MFS RVW:	11.00	
2	Svy Data	RUC Std.	RVW	Svy Data	RUC Std.	RVW	
3	<b>Pre-service:</b>	Time	Intensity (=time x ints'y)	Time	Intensity (=time x ints'y)		
4	Pre: eval & posit	43	0.0224	0.96	80	0.0224	1.79
5	Pre: scrub,dress,wait	15	0.0081	0.12	10	0.0081	0.08
6	<b>Pre-service total</b>		<b>1.08</b>			<b>1.87</b>	
7	<b>Post-service:</b>	Time	Intensity (=time x ints'y)	Time	Intensity (=time x ints'y)		
8	Immediate post	25	0.0224	0.56	30	0.0224	0.67
9	<b>Subsequent visits:</b>	Visit n	E/M RVW	(=n x RVW)	Visit n	E/M RVW	(=n x RVW)
10	ICU 99291		4.00			4.00	
11	99233		1.51			1.51	
12	99232		1.06			1.06	
13	99231		0.64			0.64	
14	Discharge 99238	0.5	1.28	0.64	0.5	1.28	0.64
15	Discharge 99239		1.75			1.75	
16	99215		1.73			1.73	
17	99214		1.08			1.08	
18	99213	1	0.65	0.65	2	0.65	1.30
19	99212	1	0.43	0.43	1	0.43	0.43
20	99211		0.17			0.17	
21	<b>Post-service total</b>		<b>2.28</b>			<b>3.04</b>	
22	<b>Intra-service:</b>	Time	IWPUT	INTRA-RVW	Time	IWPUT	INTRA-RVW
23	<b>Intra total</b>	90	0.085	7.64	90	0.068	6.09

## 2. Comparison with services with similar RVW, intra-time and total-time

Since there are no clinically similar vascular surgery services for comparison we searched the RUC database for procedures with time and RVWs that match our survey data and recommended new service RVW. Specifically, the search parameters were  $RVW \geq 11.00$  *and* intra time  $\leq 90$  minutes, *and* total time  $\leq 229$  minutes. These search criteria provided a list of all services that are valued at or higher than our recommendation, with intra and total times the same or less than our new service. There are 26 such services across a wide variety of specialties, including one service provides grounds for clinical comparison (see table below).

The closest service on this table from a clinical perspective is CPT 17108 Destruction of cutaneous vascular proliferative lesions (bolded in table, next page). Both 17108 and the new service treat vascular lesions involving the skin and subcutaneous structure. 17108 underwent RUC analysis in 1995. It is a 90-day global with RVW of 13.20, significantly greater than our new service recommendation of 11.0. 17108 has intra time of 45 minutes, significantly less than the 90-minute intra time of our new service. In addition, 17108 has total time of 95 minutes, significantly less than the 223-minute total time of our new service. Thus, the comparison vascular ablation procedure has a higher RVW for significantly less time than we are requesting for 37766.

Based on this comparison with a clinical service that also treats vascular lesions, and in light of fact that the comparison service has an RVW of 13.20 but less intra and total time than the new service, we believe an RVW of 11.0 (25<sup>th</sup> percentile value) is appropriate for the new service.

RUC Database Services with RVW $\geq 11.0$ , Intra time $\leq 90$ and Total time $\leq 223$ minutes Sorted in order of increasing RVW Proposed service and best clinical reference (next page) are in Bold							
CPT	Descriptor	RVW	Global	Time Source	Intra time	Total time	RUC meeting
<b>37766</b>	<b>Stab phlebectomy of varicose veins, one extremity, &gt;20 incisions</b>	<b>11.00 proposed</b>	090	RUC	90	223	April 2003
69905	Labyrinthectomy; transcanal	11.1	090	Harvard	73	197	
77778	Interstitial radiation source application; complex	11.19	090	Harvard	0	200	
58920	Wedge resection or bisection of ovary, unilateral or bilateral	11.36	090	Harvard	53	178	August 2000
54650	Orchiopexy, abdominal approach, for intra-abdominal testis (eg, Fowler-Stephens)	11.45	090	Harvard	0	199	Apr93
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial	11.48	090	Harvard	76	220	
45170	Excision of rectal tumor, transanal approach	11.49	090	Harvard	57	198	
49560	Repair initial incisional or ventral hernia; reducible	11.57	090	Harvard	73	212	Editorial
49560	Repair initial incisional or ventral hernia; reducible	11.57	090	RUC Time	90	221	August 2000
49560	Repair initial incisional or ventral hernia; reducible	11.57	090	RUC - Time	90	221	Apr93
47100	Biopsy of liver, wedge	11.67	090	Harvard	51	213	Feb94
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	11.67	090	Harvard	58	199	August 2000
58662	Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method	11.79	090	RUC Time	80	185.5	Apr97
27880	Amputation, leg, through tibia and fibula;	11.85	090	Harvard	68	143	
69660	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material;	11.9	090	Harvard	72	188	Aug95
22845	Anterior instrumentation; 2 to 3 vertebral segments	11.96	ZZZ	Harvard	62	62	Editorial
22845	Anterior instrumentation; 2 to 3 vertebral segments	11.96	ZZZ	Harvard	62	62	Aug95
22845	Anterior instrumentation; 2 to 3 vertebral segments	11.96	ZZZ	RUC Time	90	90	Apr95

CPT	Descriptor	RVW	Global	Source	Intra time	Total time	RUC meeting
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)	12.54	ZZZ	RUC Time	60	60	Apr95
67228	Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions; photocoagulation (laser or xenon arc)	12.74	090	Harvard	69	192	
66605	Iridectomy, with corneoscleral or corneal section; with cyclectomy	12.79	090	Harvard	59	208	
57288	Sling operation for stress incontinence (eg, fascia or synthetic)	13.02	090	Harvard	64	220	
67220	Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), one or more sessions	13.13	090	RUC Time	25	152	May98
17108	<b>Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm</b>	13.2	090	RUC Time	45	95	Aug95
47600	Cholecystectomy,	13.58	090	Harvard	64	223	Aug95
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	14.78	MMM	Harvard	42	222	Jun93
69662	Revision of stapedectomy or stapedotomy	15.44	090	Harvard	83	211	Aug95

### Services Reported with Multiple CPT Codes

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

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

**As noted in our CPT application, this service will be reported by itself in a substantial proportion of cases. At other times it will be reported with services that treat incompetent greater or lesser saphenous vein, such as 37700, 37720, 37730, or 37735.**

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

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

**The following table presents the new code along with the procedure that is most likely to be reported simultaneously in situations when the new procedure is reported with multiple codes**

CPT	Shortened Descriptor	Global	RVW	Mult Procedure Reduction	Pre Time	Intra Time	Post time
37766	Stab phlebectomy	090	11.00	11.00	58	90	81
37720	Ligation and division and complete stripping of long or short saphenous vein	090	5.66	2.83	27 Hvd	83 Hvd	102 Hvd
<b>Total</b>				<b>13.83</b>		<b>173</b>	

**FREQUENCY INFORMATION**

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

37799 Unlisted procedure, vascular surgery

**How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Vascular Surgery, Plastic Surgery, General Surgery      Commonly      Sometimes      Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Vascular Surgery, Plastic Surgery, General Surgery      Frequency: 500

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

Specialty: Vascular Surgery, Plastic Surgery, General Surgery      Frequency: 250

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

---

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
090 Day Global Period  
Facility Direct Inputs**

<b>CPT</b>	<b>DESCRIPTION</b>	<b>GLOBAL</b>
37765	Stab phlebectomy of varicose veins, one extremity; up to and including 20 incisions	90
37766	Stab phlebectomy of varicose veins, one extremity; more than 20 incisions	90

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:** The direct practice expense details were developed by physicians from the American Association of Vascular Surgeons representing a broad mix of categories of type of practice and geographic areas.

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time (prior to admission):** For each of these 90-day facility only procedures, the standard "typical" 60 minutes have been applied.

**Service period clinical staff time (admission to discharge):**

Pre-service: N/A

Intra-service: N/A

Post-service: 6 minutes of clinical staff time for work related to outpatient discharge.

**Post-service period clinical staff time:** Standard EM postop visit time for clinical staff has been applied for each office visit.

**SUPPLIES AND EQUIPMENT:**

Minimal supplies and equipment necessary to perform the procedures and for post op visit supplies are presented.

---

37765-66 PE Details (April 2003 RUC)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	37765		37766	
		Stab phlebectomy of varicose veins, one extremity; up to and including 20 incisions		Stab phlebectomy of varicose veins, one extremity, more than 20 incisions	
GLOBAL PERIOD		90		90	
LOCATION		NonFac	Fac	NonFac	Fac
<b>TOTAL CLINICAL LABOR TIME</b>	1130	N/A	129.0	N/A	129.0
PRE-SERVICE PERIOD TOTAL TIME	1130		60.0		60.0
SERVICE PERIOD TOTAL TIME	1130		6.0		6.0
POST-SERVICE PERIOD TIME	1130		63.0		63.0
<b>PRE-SERVICE PERIOD</b>					
Complete pre-service diagnostic & referral forms	1130		5		5
Coordinate pre-surgery services	1130		20		20
Schedule space and equipment in facility	1130		8		8
Provide pre-service education/obtain consent	1130		20		20
Follow-up phone calls & prescriptions	1130		7		7
Other Clinical Activity (please specify)					
<b>SERVICE PERIOD</b>					
Pre-service			0		0
Intra-service			0		0
Post-Service					
Discharge day management 99238 --12 minutes 99239 --15 minutes	1130		6		6
Other Clinical Activity (please specify)					
<b>POST-SERVICE PERIOD</b>					
Conduct phone calls/call in prescriptions					
<i>List Number and Level of Office Visits</i>					
99211 16 minutes					
99212 27 minutes			1		1
99213 36 minutes			1		1
99214 53 minutes					
99215 63 minutes					
<b>Total Office Visit Time</b>	1130		63		63
Other Activity (please specify)					
<b>MEDICAL SUPPLIES</b>					
minimum visit package (multispecialty)	PEAC pack		2		2
post-op incision care kit	PEAC kit		1		1
<b>Equipment</b>					
exam table	E11001		1		1
exam lamp	E30006		1		1

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Bone Marrow Procedures**

CPT codes 38207 – 38215, which describe a series of bone marrow and stem cell harvesting services, were created for *CPT 2003* and will be slightly modified in *CPT 2004*. The RUC had previously reviewed this series of services and had developed interim work relative value recommendations. The RUC had requested that the specialty re-survey these codes after the CPT Editorial revised the nomenclature for the codes. In the December 31, 2002 *Final Rule*, CMS announced that it had decided that relative values should not be assigned to these services.

At the April 2003 RUC meeting, the specialty informed the RUC that they were currently discussing this issue with CMS and hoped to resolve the issue regarding the assignment of work relative values to these services in the near future. Upon resolution of this issue with CMS, the specialty will conduct a survey and present relative value recommendations to the RUC. The specialty requested that the RUC's earlier "interim" recommendations remain in effect until the specialty has the opportunity to re-survey these codes. The RUC accepted this request and AMA RUC staff will monitor the specialties discussions with CMS to determine an appropriate time to re-schedule this issue on the RUC's agenda.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<u>Codes 38207 – 38215 describe various steps used to preserve, prepare and purify bone marrow/stem cells prior to transplantation or reinfusion. Each code may be reported only once per day regardless of the quantity of bone marrow/stem cells manipulated.</u>				
38207	X3	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage  (For diagnostic cryopreservation and storage, see 88240)	XXX	0.47  (interim)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
38208	X4	thawing of previously frozen harvest, <u>without washing</u>  (For diagnostic thawing and expansion of frozen cells, see 88241)	XXX	0.56  (interim)
38209	X5	<u>thawing of previously frozen harvest, with washing of harvest</u>	XXX	0.24  (interim – based on old language, will need to be adjusted)
38210	X6	specific cell depletion within harvest, T-cell depletion	XXX	0.94  (interim)
38211	X7	tumor cell depletion	XXX	0.71  (interim)
38212	X8	red blood cell removal	XXX	0.47  (interim)
38213	X9	platelet depletion	XXX	0.24  (interim)
38214	X10	plasma (volume) depletion	XXX	0.24  (interim)
38215	X11	cell concentration in plasma, mononuclear, or buffy coat layer	XXX	0.55  (interim)
<u>(Do not report 88180, 88182 in conjunction with 38207-38215)</u>				

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

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Esophagogastroduodenoscopy (EGD) with Ultrasound Examination (EUS)**

The CPT Editorial Panel created two new codes and revised two existing codes to clarify the differences in endoscopic ultrasound examinations. Code 43237 *Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination limited to the esophagus* represents esophagogastroduodenoscopy with the endoscopic ultrasound examination limited to the esophagus. Code 43238 *Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)* represents esophagogastroduodenoscopy (EGD) with the endoscopic ultrasound examination (EUS) and a fine needle aspiration/biopsy limited to the esophagus. The existing codes 43242 and 43259 were revised to clarify that they involve an EUS examination of the complete upper GI tract, not just one confined solely to the esophagus or solely to the stomach. The specialty societies presented a family of esophagogastroduodenoscopy codes, however the initial recommendation omitted code 43259. During the presentation it appeared that the value for this code may change since CMS would revisit the valuation of code 43259 after the review of the two new EGD codes (43237 and 43238) at the April 2003 RUC meeting. The RUC felt that all the EGD codes needed to be examined at the same time and asked the specialty to revise its presentation. The following RUC recommendations are based on the revised presentation.

43237

This code represents a diagnostic EGD with the ultrasound examination limited to the esophagus. Although the survey data supported a higher value, the RUC felt that a value based on the survey data would not place the code in a proper rank order, and the following building block approach was used. The value assigned to a diagnostic EGD, code 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = 2.39) was used a starting point for valuation. The RUC added the incremental work assigned to code 43231 *Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination* (work RVU = 3.19) and then subtracted the work RVU of code 43000 *Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = 1.59), which results in a value of 1.60. This incremental work value represents the intra-service work only of EUS. Adding 1.60 and 2.39 results in a recommendation of 3.99 for code 43237.

**The RUC recommends a work RVU of 3.99 for code 43237.**

#### 43238

This code represents diagnostic EGD with the ultrasound examination and fine needle aspiration/ biopsy limited to the esophagus. The RUC did not use a building block approach for this code since it would have produced a rank order anomaly. Therefore this code was cross walked to other codes outside of the GI endoscopy procedures that involved similar time and complexity. In particular code 31641 *Bronchoscopy, (rigid or flexible); with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy)* (work RVU = 5.03) had the same intra-service time of 70 minutes as 43238. Therefore the RUC agreed to crosswalk to value of 5.03 since this was reasonable comparison of physician work and placed the code in proper rank order.

**The RUC recommends a work RVU of 5.03 for code 43238.**

#### 43242

This code represents EGD with endoscopic ultrasound and fine needle aspiration (FNA)/biopsy. The editorial changes do not reflect any change in physician work. This code has been previously valued by the RUC at 7.31 work RVUs. The RUC verified the value of this service by comparing it to 52343 *Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU = 7.20)

**The RUC recommends a work RVU of 7.31 for code 43242.**

#### 43259

This code represents EGD with endoscopic ultrasound. This code was assigned a value by CMS of 4.89 RVUs after the second five-year review although the RUC recommendation was for 8.59 work RVUs. The current valuation of 4.89 work RVUs presents rank order anomalies with other GI endoscopic procedures, including GI endoscopic ultrasound procedures. This code was compared to other GI endoscopy codes with similar complexity such as code 43260 *Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = 5.96 and code 45385 *Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique* (work RVU = 5.31). The RUC agreed that the complexity is similar to 45385, but slightly less and recommend an RVU of 5.20. It is anticipated that approximately 20% of procedures currently reported with 43259 will now be reported using 43237. The final work RVU recommendations take this into account so that the recommended values for the new codes are work neutral recommendations.

**The RUC recommends a work RVU of 5.20 for code 43259.**

#### Practice Expense

The RUC approved the practice expense recommendations for 43237 and 43238 that were based on previously approved practice expense inputs for GI codes.

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

CPT Code (●New)	Track ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
43235		Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	000	2.39 (no change)
●43237	AA1	Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination limited to the esophagus  (Do not report code 43227 in conjunction with 76975)	000	3.99
●43238	AA2	with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)  (Do not report code 43238 in conjunction with 76942 or 76975)	000	5.03
▲43242	AA3	with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic	000	7.31 (no change)

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

CPT Code (•New)	Track ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		<u>ultrasound examination of the esophagus, stomach, and either the duodenum and/or jejunum as appropriate)</u>		
▲43259	AA4	with endoscopic ultrasound examination, <u>including the esophagus, stomach, and either the duodenum and/or jejunum as appropriate</u>	000	5.20

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

---

CPT Code: 43237 Tracking Number: AA1 Global Period: 000 Recommended RVW: 3.99

**CPT Descriptor:** Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination limited to the esophagus

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** A 62 year old male with progressive dysphagia has been identified to have an exophytic mass lesion in the mid and distal esophagus that on prior biopsy is proven to be an adenocarcinoma. A CT examination of the chest and abdomen demonstrates thickening of the mid and distal esophagus without evidence of distant metastases. The physician is requested to further stage the tumor with endoscopic ultrasound. A small caliber gastroscope is inserted per ora into the esophagus and, with some difficulty, is negotiated past the tumor into the stomach and duodenum. An esophagogastroduodenoscope (EGD) examination is performed which identifies an esophageal tumor that extends into the proximal stomach. The gastroscope is removed and the radial scanning echoendoscope is advanced per ora into the esophagus. As the echoendoscope is able to traverse approximately 1/3 of the length of the tumor but, due to tumor stenosis (and the larger caliber of the echoendoscope compared to the standard EGD), further advancement of the echoendoscope is precluded. On imaging, transmural infiltration of the tumor is appreciated and abutment versus invasion of the posterior trachea is identified. Several malignant appearing peritumoral lymph nodes are identified. No suspicious lymphadenopathy is seen in the peri esophageal space proximal to the tumor. The echoendoscope is withdrawn. The patient is taken to the recovery suite where postprocedure vital signs are monitored. The physician records a postprocedure note, prepares postprocedure orders, dictates a note to the referring physician, and discusses the findings with the family and patient. The patient is discharged when vital signs are stable.

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

**Description of Pre-Service Work:**

Review with the patient any symptoms and ascertain if dysphagia has been a problem to identify if technical problems may arise when using the larger caliber echoendoscope to traverse the esophagus. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment and cardiopulmonary evaluation is performed. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays are reviewed. The CT technique and level of resolution are reviewed to determine the adequacy of the examination for identifying a neoplastic process. Indicate to the patient that these risks are higher with an endoscopic ultrasound examination than standard endoscopy due to the longer exam duration, the increased caliber of the instruments as well as the possibility that the lesion may require a transmural biopsy. Explain that if the lesion appears to be cystic and undergoes a fine-needle aspiration biopsy that intravenous antibiotics will be administered during the exam and oral antibiotics will need to be continued for 48 hours after the exam.

**Description of Intra-Service Work:**

An esophagogastroduodenoscope (EGD) examination is performed which identifies an esophageal tumor that extends into the proximal stomach. The gastroscope is removed and the radial scanning echoendoscope is advanced per ora into the esophagus. As the echoendoscope is able to traverse approximately 1/3 of the length of the tumor but, due to tumor stenosis (and the larger caliber of the echoendoscope compared to the standard EGD), further advancement of the echoendoscope is precluded. On imaging, transmural infiltration of the tumor is appreciated and abutment versus invasion of the posterior trachea is identified. Several malignant appearing peritumoral lymph nodes are identified. No suspicious lymphadenopathy is seen in the peri esophageal space proximal to the tumor. The echoendoscope is withdrawn.

**Description of Post-Service Work:**

The patient is taken to the recovery suite where postprocedure vital signs are monitored. The physician records a postprocedure note, prepares postprocedure orders, dictates a note to the referring physician, and discusses the findings with the family and patient. The patient is discharged when vital signs are stable.

**SURVEY DATA**

<b>Presenter(s):</b>		Maurits Wiersema, MD Joel Brill, MD				
<b>Specialty(s):</b>		American Society of Gastrointestinal Endoscopy American Gastroenterological Association				
<b>CPT Code:</b>		43237				
<b>Sample Size:</b>	90	<b>Resp n:</b>	27	<b>Resp %:</b>	30%	
<b>Sample Type:</b> Panel Sample						
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		2.39	4.615	4.89	5.865	9.39
<b>Pre-Service Evaluation Time:</b>		21	26	31	31	36
<b>Pre-Service Positioning Time:</b>						
<b>Pre-Service Scrub, Dress, Wait Time:</b>						
<b>Intra-Service Time:</b>		35	40	45	55	85
<b>Immed. Post-time</b>		31.5	36.5	36.5	44	66.5
<b>Post-Service</b>		<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Critical Care time/visit(s):</b>						
<b>Other Hospital time/visit(s):</b>						
<b>Discharge Day Mgmt:</b>						
<b>Office time/visit(s):</b>						

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	3.58	2.39

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

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

**Number of respondents who choose Key Reference Code:** All comparisons were to base code 43235

**TIME ESTIMATES (Median)**

New/Revis.  
CPT Code: 43235  
43237

	Base Code: <u>43235</u>
Median Pre-Service Time	31
Median Intra-Service Time	45
Median Immediate Post-service Time	25
Median Critical Care Time	36.5
Median Other Hospital Visit Time	N/A
Median Discharge Day Management Time	N/A
Median Office Visit Time	N/A
Median Total Time	112.5

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.11	2.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4	2.33
Urgency of medical decision making	3.78	2.44

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.33	2.37
Physical effort required	3.63	2.15

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.69	2.19
---	------	------

Outcome depends on the skill and judgement of physician	4.3	2.48
---	-----	------

Estimated risk of malpractice suit with poor outcome	3.63	2.56
--	------	------

**INTENSITY/COMPLEXITY MEASURES**

<u>CPT Code</u>	<u>Reference Service 1</u>
-----------------	----------------------------

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.59	2.04
----------------------------------	------	------

Intra-Service intensity/complexity	4	2.41
------------------------------------	---	------

Post-Service intensity/complexity	3.74	2.33
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

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

This procedure consists of a diagnostic EGD and a transendoscopic ultrasound procedure limited to the esophagus. We compared the incremental time, complexity and work value for this code to the diagnostic upper GI endoscopy procedure (EGD), code 43235, which has an RVW of 2.39. The median incremental RVW recommended by the survey respondents over and above the base code was 2.5 RVUs, or a total of 4.89. The median incremental intra time over the base code was 20 minutes. The median incremental pre time was 15 minutes and the median post incremental time was 10 minutes. It is clear that the complexity of this procedure is considerably greater than the base code. However, considering the amount of incremental time involved, we concluded that the median RVW recommended might be excessive considering the IWPUT that would result. We therefore are recommending an RVW of 4.5, which is slightly less than the 25th percentile.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

---

**FREQUENCY INFORMATION**

How was this service previously reported? 43242, 43259 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Gastroenterology \_\_\_\_\_  Commonly  Sometimes  Rarely

Specialty \_\_\_\_\_  Commonly  Sometimes  Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology \_\_\_\_\_ Frequency 450-1000 \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty Gastroenterology \_\_\_\_\_ Frequency 50% \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

---

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

---

CPT Code: 43238 Tracking Number: AA2 Global Period: 000 Recommended RVW: 5.03

**CPT Descriptor:** Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** A 62 year old male with progressive dysphagia has been identified to have an exophytic mass lesion in the mid and distal esophagus that on prior biopsy is proven to be a squamous cell carcinoma. A CT examination of the chest and abdomen demonstrates thickening of the mid and distal esophagus without distant metastases. The physician is requested to further stage the tumor with endoscopic ultrasound. A small caliber gastroscope is inserted per ora into the esophagus and, with some difficulty, is negotiated past the tumor into the stomach and duodenum. An esophagogastroduodenoscope (EGD) examination is performed which identifies a distal esophageal tumor that is partially obstructing and extends into the proximal stomach. The gastroscope is removed and the radial scanning echoendoscope is advanced per ora into the esophagus. As the echoendoscope is advanced into the esophagus, the physician performs ultrasound evaluation of the esophagus and mediastinal structures. The echoendoscope is able to traverse the proximal 1/3 the length of the tumor but, due to tumor stenosis (and the larger caliber of the echoendoscope compared to the standard EGD), further advancement of the echoendoscope is precluded. On imaging, transmural infiltration of the tumor is appreciated but no extension into adjacent structures is seen. Proximal to the beginning of the tumor, a 10-mm lymph node is identified into the aortopulmonic window. As this impacts on the operability of the patient, you proceed to perform an endoscopic ultrasound-guided biopsy of the lymph node. In order to do so, the radial scanning echoendoscope is removed and the linear scanning echoendoscope is advanced per ora into the esophagus to the level of the previously identified lymph node at the aortopulmonic window. Using real time ultrasound guidance, a 22-gauge needle is advanced through the linear scanning endoscope into the lymph node. With each pass of the needle, tissue is obtained and evaluated by the cytotechnologist. After 3 passes, the attendant cytotechnologist indicates an adequate specimen has been procured. The endoscope is withdrawn. The patient is taken to the recovery suite where postprocedure vital signs are monitored. The physician records a postprocedure note describing the endoscopic examination, and dictates a second note describing the ultrasound examination and interpretation. The physician prepares postprocedure orders, dictates a note to the referring physician, and discusses the findings with the family and patient. The referring physician is called and apprised of the findings. The patient is discharged when vital signs are stable.

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

**Description of Pre-Service Work:**

Review with the patient any symptoms and ascertain if dysphagia has been a problem to identify if technical problems may arise when using the larger caliber echoendoscope to traverse the esophagus. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment and cardiopulmonary evaluation is performed. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays are reviewed. The CT technique and level of resolution are reviewed to determine the adequacy of the examination for identifying a neoplastic process. Indicate to the patient that these risks are higher with an endoscopic ultrasound examination than standard endoscopy due to the longer exam duration, the increased caliber of the instruments as well as the possibility that the lesion may require a transmural biopsy. Explain that if the lesion appears to be cystic and undergoes a fine-needle aspiration biopsy that intravenous antibiotics will be administered during the exam and oral antibiotics will need to be continued for 48 hours after the exam.

**Description of Intra-Service Work:**

An esophagogastroduodenoscopy (EGD) examination is performed which identifies a distal esophageal tumor that is partially obstructing and extends into the proximal stomach. The gastroscope is removed and the radial scanning echoendoscope is advanced per ora into the esophagus. As the echoendoscope is advanced into the esophagus, the physician performs ultrasound evaluation of the esophagus and mediastinal structures. The echoendoscope is able to traverse the proximal 1/3 the length of the tumor but, due to tumor stenosis (and the larger caliber of the echoendoscope compared to the standard EGD), further advancement of the echoendoscope is precluded. On imaging, transmural infiltration of the tumor is appreciated but no extension into adjacent structures is seen. Proximal to the beginning of the tumor, a 10-mm lymph node is identified into the aortopulmonic window. As this impacts on the operability of the patient, you proceed to perform an endoscopic ultrasound-guided biopsy of the lymph node. In order to do so, the radial scanning echoendoscope is removed and the linear scanning echoendoscope is advanced per ora into the esophagus to the level of the previously identified lymph node at the aortopulmonic window. Using real time ultrasound guidance, a 22-gauge needle is advanced through the linear scanning endoscope into the lymph node. With each pass of the needle, tissue is obtained and evaluated by the cytotechnologist. After 3 passes, the attendant cytotechnologist indicates an adequate specimen has been procured. The endoscope is withdrawn.

**Description of Post-Service Work:**

The patient is taken to the recovery suite where postprocedure vital signs are monitored. The physician records a postprocedure note describing the endoscopic examination, and dictates a second note describing the ultrasound examination and interpretation. The physician prepares postprocedure orders, dictates a note to the referring physician, and discusses the findings with the family and patient. The referring physician is called and apprised of the findings. The patient is discharged when vital signs are stable.

**SURVEY DATA**

<b>Presenter(s):</b>	Maurits Wiersema, MD Joel Brill, MD				
<b>Specialty(s):</b>	American Society of Gastrointestinal Endoscopy American Gastroenterological Association				
<b>CPT Code:</b>	43238				
<b>Sample Size:</b> 90	<b>Resp n:</b> 26	<b>Resp %:</b> 29%			
<b>Sample Type:</b> Panel Sample					
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	4.39	6.39	6.89	7.31	10.39
<b>Pre-Service Evaluation Time:</b>	21	26	31	31	46
<b>Pre-Service Positioning Time:</b>					
<b>Pre-Service Scrub, Dress, Wait Time:</b>					
<b>Intra-Service Time:</b>	45	56.25	70	75	100
<b>Immed. Post-time:</b>	31.5	36.5	41.5	46.5	56.5
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>					
<b>Critical Care time/visit(s):</b>					
<b>Other Hospital time/visit(s):</b>					
<b>Discharge Day Mgmt:</b>					
<b>Office time/visit(s):</b>					

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	3.58	2.39

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

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

**Number of respondents who choose Key Reference Code:** All respondents compared procedure to base code 43235

<u>TIME ESTIMATES (Median)</u>	<u>New/Revis. CPT Code:</u> <u>43238</u>	<u>Base Code:</u> <u>43235</u>
Median Pre-Service Time	31	16
Median Intra-Service Time	70	25
Median Immediate Post-service Time	41.5	26.5
Median Critical Care Time	N/A	
Median Other Hospital Visit Time	N/A	
Median Discharge Day Management Time	N/A	
Median Office Visit Time	N/A	
<b>Median Total Time</b>	<b>142.5</b>	<b>67.5</b>

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.15	2.54
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.27	2.31
Urgency of medical decision making	4.04	2.46

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.65	2.35
Physical effort required	4.38	2.12

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.31	2.23
---	------	------

Outcome depends on the skill and judgement of physician	4.69	2.46
---	------	------

Estimated risk of malpractice suit with poor outcome	4.19	2.58
--	------	------

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.73	2.08
----------------------------------	------	------

Intra-Service intensity/complexity	4.69	2.5
------------------------------------	------	-----

Post-Service intensity/complexity	4.08	2.23
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

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

This procedure consists of a diagnostic EGD with transendoscopic ultrasound examination limited to the esophagus and an ultrasound guided fine needle aspiration/biopsy(s) also limited to the esophagus. We compared the incremental time, complexity and work value for this code to the diagnostic upper GI endoscopy procedure (EGD), code 43235, which has an RVW of 2.39. The median incremental RVW recommended by the survey respondents over and above the base code was 4.5 RVUs or a total of 6.89. The median incremental intra time for the procedure was 45 minutes and the pre and post incremental time were both 15 minutes each. It is clear that the complexity of this procedure is considerably greater than the base code. However, considering the amount of incremental time involved, we concluded that the median RVW would be excessive considering the IWP/UT that would result. It also appears to us that the median time estimates to perform this procedure over and above the base code might be excessive. This is particularly true with pre and post time. Currently, esophagoscopy with EUS (code 43231) is assigned 3.19 RVWs and the same procedure with fine needle aspiration/biopsy(s) (code 43232) is assigned an RVW of 4.48. We think the 1.29 increment (4.48 minus 3.19) is an appropriate increment for the FNA/biopsy portion of the service over and above the RVW being recommended for code 43237. This will avoid the introduction of any rank order anomaly. Thus, we recommend an RVW of 5.79 for code 43238--4.5 plus 1.29. This recommendation is substantially less than the 25th percentile of the survey data.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)\_\_\_\_\_

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

**FREQUENCY INFORMATION**

How was this service previously reported? 43242, 43259 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Gastroenterology \_\_\_\_\_  Commonly  Sometimes  Rarely

Specialty \_\_\_\_\_  Commonly  Sometimes  Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology \_\_\_\_\_ Frequency \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency 500-1000

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

Specialty Gastroenterology \_\_\_\_\_ Frequency \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

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

CPT Code: 43259Global Period: 000

Recommended RVW: 5.20

CPT Descriptor: Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** A 67-year-old woman who develops painless jaundice is identified to have dilation of her bile duct and pancreatic duct on CT scan. A discrete mass lesion is not identified. The patient is referred for an endoscopic ultrasound to identify if a mass lesion is present and if so then stage the tumor and determine operability.

**Description of Pre-Service Work:****Description of Intra-Service Work:****Description of Post-Service Work:****SURVEY DATA:**Presenter(s) Joel Brill, MD; Thomas Browning, MD; Maurits Wiersema, MDSpecialty(s): American Gastroenterological Association (AGA); American Society for Gastrointestinal EndoscopySample Size: 62 Response Rate: (%): 53 Median RVW: 10.76

Type of Sample (Circle One): random,  panel, convenience. Explanation of sample size: Physician representatives from RUC Advisory Committee met to consider revisions to the recommendations from the Five Year Review.

25th Percentile RVW: 9.56 75th Percentile RVW: 13.74 Low: 4.78 High: 16.73Median Pre-Service Time: 28 Median Intra-Service Time: 6925th Percentile Intra-Svc Time: 64 75th Percentile Intra-Svc Time: 74Low: 29 High: 114

Median Post-Service Time:

	<u>Total Time</u>	Level of Service by CPT Code (List CPT Code & # of Visits)
--	-------------------	---

Immediate Post Service Time:	<u>36</u>
------------------------------	-----------

**CONSENSUS PANEL RECOMMENDATIONS**Pre-Service Time: 28 (Base code pre-time is 16 min.)Intra-Service Time.: 69 (Base code intra-time is 25 min.)Post-Service Time: 36 (Base code post-time is 26.5 min.)

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	000	2.39

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

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

**TIME ESTIMATES (Median)**

**New/Revis. CPT Code:**      **Key Reference CPT Code:**

Recommended Pre-Time	28	16
Recommended Intra-Time	69	25
Recommended Immediate Post-service Time	36	26.5
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.50	2.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.56	2.29
Urgency of medical decision making	4.03	2.23

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.88	2.26
Physical effort required	4.25	1.97

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.71	2.23
Outcome depends on the skill and judgement of physician	4.84	2.48

Estimated risk of malpractice suit with poor outcome	4.03	3.00
--	------	------

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference**  
**Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.94	2.32
Intra-Service intensity/complexity	4.76	2.44
Post-Service intensity/complexity	3.94	2.18

**ADDITIONAL RATIONALE**

**Describe the process by which your specialty society reached your final recommendation.**

RUC Advisory Committee members representing ASGE and AGA met to address concerns raised by CMS in the November 1, 2001 Final Rule regarding the proposed update in the Five Year Review for CPT code 43259 (EGD with EUS). CMS stated concerns about the inconsistency between 43259 and the RUC's reevaluation of CPT code 43231. Representatives from Gastroenterology have therefore revised their recommendation for 43259 to bring it in line with existing GI endoscopic codes which include ultrasound examination. The recommended RVWs for the EUS codes were all, save one code, below the median survey response and were derived through a consensus process that took into account the specific components of the service.

**FREQUENCY INFORMATION**

How was this service previously reported? 43259, RVW 4.59

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

Specialty: **Gastroenterology**      **Rarely**

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: **Gastroenterology**      Frequency: **13,000**

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

Specialty: **Gastroenterology**      Frequency: **7,500**

Do many physicians perform this service across the United States? **NO**

**AMA/Specialty Society Update Process  
RUC Summary of Recommendation  
000 Day Global Period  
Out-Of-Office Direct Inputs**

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: 000

Tracking Number: AA1/AA2 Reference Code 1 \_\_\_\_\_ Reference Code 2 \_\_\_\_\_

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
 \_\_\_\_\_ Single Specialty Group  
 \_\_\_\_\_ Multispecialty Group  
 \_\_\_\_\_ Medical School Faculty Practice Plan

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

Since most Gastroenterologists do not perform these procedures, input on practice expenses was obtained from physicians who are familiar with these services. A consensus committee including representatives of the AGA and American Society of Gastrointestinal Endoscopy reviewed the data for codes 43237 and 43238, upper GI endoscopy ultrasound (EUS) confined to the esophagus. Analysis of the data revealed that EUS procedures are rarely performed outside of the hospital setting; thus the recommendation was made to price the service only in the facility setting. The staff time of 19 minutes that is recommended for the pre service activities of office staff is consistent with other EUS procedures that have been reviewed by the Practice Expense Advisory Committee (PEAC) during 2002 and 2003.

**Please describe the clinical activities of your staff:**

*Pre-Service Clinical Labor Activities:* See spreadsheet attached.

*Intra-Service Clinical Labor Activities:*

HCFA's Staff Type Code**	Clinical Labor	Pre-Service Time	Service Period	Coordination of Care*	Cost Estimate and Source (if applicable)
1130	RN/LPN/MTA	19		3	

\*By staff in the physician's office during the service period.

\*\*From HCFA's Labor, Medical Supply, and Equipment List. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)

\*From HCFA's Labor, Medical Supply, and Equipment List. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	Cost Estimate and Source (if applicable)

\*From HCFA's Labor, Medical Supply, and Equipment List. If not listed, please provide full description, estimated cost, and cost source.

	A	B	C	D	E	F	G	
1	<b>EGD with Ultrasound Examination (EUS)</b>	<b>CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE</b>		43237	43238			
2					Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination limited to the esophagus	Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)		
3				Global ->	0	0		
4				Location ->	Office	Facility	Office	Facility
5	TOTAL RN/LPN/MTA CLINICAL LABOR TIME	RN/LPN/MTA	NA	22	NA	22		
6	TOTAL RN CLINICAL LABOR TIME	RN						
7	PRE-SERV CLINICAL LABOR TIME	RN/LPN/MTA		19		19		
8	CON SED CLINICAL LABOR TIME	RN						
9	SERVICE PERIOD CLINICAL LABOR TIME	RN/LPN/MTA		0		0		
10	POST-SERV CLINICAL LABOR TIME	RN/LPN/MTA		3		3		
11	<b>PRE-SERVICE</b>							
12	Complete pre-service diagnostic & referral forms	RN/LPN/MTA		3		3		
13	Coordinate pre-surgery services - review tests	RN/LPN/MTA		5		5		
14	Schedule space and equipment in facility	RN/LPN/MTA		3		3		
15	Provide pre-service education/obtain consent	RN/LPN/MTA		5		5		
16	Phone calls & prescriptions	RN/LPN/MTA		3		3		
17	Other Clinical Activity (please specify)							
18	<b>SERVICE PERIOD</b>							
19	<b>Intra-service</b>							
20	Dischg day mgmt (99238 12 min) (99239 15 min)	RN/LPN/MTA						
21								
22	<b>Post Service</b>							
23	Follow up phone call			3		3		

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2003

**Naso- or ORO-Gastric Tube Placement**

A new code for CPT 2001, 43752, *Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)* was added to CPT for naso- or oro-gastric tube placement by a physician (e.g. requiring additional skill or involving additional risk). The cross-reference regarding imaging guidance was deleted, as fluoroscopic guidance is now incorporated in the code descriptor. The cross-reference regarding critical care and neonatal intensive care services was revised to instruct the user in the appropriate use of this code with these services.

CMS then reviewed the code and believed that the code should include fluoroscopic guidance. In August 2002, the CPT Editorial Panel revised code 43752 for its 2003 cycle to include fluoroscopic guidance, and image documentation and report. For the 2003 Medicare Fee Schedule, CMS created code G0272 *Naso/oro gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)* (Work RVU = 0.32) for one year until an identical CPT code becomes effective.

In February 2003, the RUC reviewed the specialty society's survey results for CPT Code 43752 carefully in conjunction with relative physician work of the following procedures:

44500 *Introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure)* (Work RVU = 0.49)

74340 *Introduction of long gastrointestinal tube (eg, Miller-Abbott), including multiple fluoroscopies and films, radiological supervision and interpretation* (Work RVU = 0.54)

76000 *Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)* (Work RVU = 0.17)

91105 *Gastric intubation, and aspiration or lavage for treatment (eg, for ingested poisons)* (Work RVU = 0.37)

The RUC understood that the typical patient for CPT code 43752 was one for which there had been multiple failed attempts by hospital staff to establish the tube placement. The RUC compared CPT code 43752 to CPT code 44500 and 74340 as fluoroscopy is separately reported when performing 44500. A combined work value of 1.03 is computed for this service, as compared to the recommended work RVU of 0.82 for 43752. The RUC also agreed that CPT code 43752 compared favorably with common complex E&M services. The RUC disagreed with CMS's current valuation of the physician work for the code, and believed the specialty society's survey results reflected the true physician work involved. **The RUC recommends a relative work value for code 43752 of 0.82.**

**Practice Expense:**

This service is only provided in a facility setting, therefore, the RUC has not recommended any practice expense inputs for this code.

CPT Code (•New)	Track ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
▲ 43752	D1	<p>Naso- or oro-gastric tube placement, <del>neecessitating</del> <u>requiring</u> physician's skill and <u>fluoroscopic guidance (includes fluoroscopy, image documentation and report)</u></p> <p><del>(If imaging guidance is performed, use 76000)</del></p> <p>(For enteric tube placement, see 44500, 74340)</p> <p>(Do not report 43752 in conjunction with critical care codes 99291-99292, <del>or</del> neonatal <u>intensive critical</u> care codes; 99295-99296 <del>99298</del>, <u>pediatric critical care codes 99293-99294 or low birth weight intensive care service codes 99298-99299</u>)</p>	XXX	0.82

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

---

CPT Code: 43752 Tracking Number: D1 Global Period: XXX Recommended RVW: 0.82

CPT Descriptor: Naso- or oro- gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)

~~(If imaging guidance is performed, use 76000)~~

(For enteric tube placement, see 44500, 74340)

(Do not report 43752 in conjunction with critical care codes 99291-99292, or neonatal intensive critical care codes, 99295-99296 99298, pediatric critical care codes 99293-99294 or low birth weight intensive care service codes 99298-99299)

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:**

A 74 year old patient with a known hiatal hernia recently suffered a stroke and requires placement of a nasogastric tube for feeding. Attempts at nasogastric tube placement were made by the nursing staff, and each time the tube was mispositioned in the distal esophagus. The patient's physician ordered fluoroscopically guided nasogastric tube placement to assure proper placement of the tube in the stomach.

**Description of Pre-Service Work:**

- The patient's chart is reviewed and the order confirmed
- Discussion with staff about difficulties encountered with previous attempts
- Pertinent previous radiographs are reviewed
- The procedure is discussed with the patient

**Description of Intra-Service Work:**

- Preliminary fluoroscopic evaluation of the thorax is performed
- The patient's swallowing function is checked with water
- The nasogastric tube is placed into the proximal esophagus in the usual manner
- Fluoroscopy is used to aid manipulation of the tube through the hiatal hernia and across the gastroesophageal junction
- Fluoroscopy and spot radiographs are used to confirm placement of the tube in the stomach
- The tube is secured at the nose in the usual manner
- The procedure is documented in the patient's chart

**Description of Post-Service Work:**

- The referring physician and nursing staff are notified of the result of the procedure
  - The report of the procedure is dictated for the medical record
  - The report of the procedure is reviewed and signed
-

**SURVEY DATA**

<b>Presenter(s):</b> Bibb Allen, Jr., M.D.	
<b>Specialty(s):</b> American College of Radiology	
<b>CPT Code:</b> 43752	
<b>Sample Size:</b> 78	<b>Resp n:</b> 32 <b>Resp %:</b> 41%
<b>Sample Type:</b> Random	
	<b>Low    25th pctl    Median    75th pctl    High</b>
<b>Survey RVW:</b>	0.40    0.54    1.00    2.50    3.00
<b>Pre-Service Time:</b>	1.00    5.00    5.00    10.00    15.00
<b>Intra-Service Time:</b>	10.00    15.00    20.00    25.00    30.00
<b>Post-Service</b>	<b>Total Min*    CPT code / # of visits</b>
<b>Immed. Post-time:</b>	<b>5.00 (median)</b>
<b>Critical Care time/visit(s):</b>	
<b>Other Hospital time/visit(s):</b>	
<b>Discharge Day Mgmt:</b>	
<b>Office time/visit(s):</b>	

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
44500	Introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure)	000	0.49

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

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

**TIME ESTIMATES (Median)**

New/Revis.  
CPT Code: 43752  
Key Reference CPT  
Code: 44500

Median Pre-Service Time	5.00	6.00
Median Intra-Service Time	20.00	25.00
Median Immediate Post-service Time	5.00	5.00
Median Critical Care Time		
Median Other Hospital Visit Time		
Median Discharge Day Management Time		
Median Office Visit Time		
<b>Median Total Time</b>	<b>30.00</b>	<b>36.00 (RUC Data)</b>

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	1.83	2.15
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.60	1.94
Urgency of medical decision making	1.69	1.94

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.23	2.76
Physical effort required	3.00	2.47

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.29	1.97
Outcome depends on the skill and judgement of physician	3.06	2.62

Estimated risk of malpractice suit with poor outcome	2.49	2.44
--	------	------

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	1.57	1.89
----------------------------------	------	------

Intra-Service intensity/complexity	3.23	2.77
------------------------------------	------	------

Post-Service intensity/complexity	1.46	1.71
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Since the RUC rules allow only one reference service code, the ACR chose CPT code 44500 as it was cited most frequently in our survey. However, CPT code 44500 is typically performed with fluoroscopic guidance and, CPT code 74340 is also reported. This makes the value of the combined procedure 1.03 RVW as shown in the table below. Since 43752 includes the fluoroscopic guidance, no additional guidance or fluoroscopy codes can be reported. Therefore, the RUC should consider the true value of the reference service code to be 1.03 RVW instead of 0.49 RVW. The ACR's recommendation of 0.82 RVW preserves rank order and supports our median survey time of 30 minutes. The recommended value of 0.82 RVW for CPT code 43752 compares favorably with E&M services such as 99232 at 1.06 RVW with 30 minutes total time and 25 minutes face to face time and 99213 at 0.67 RVW with 23 minutes total time and 15 minutes face to face time.

While the time and intensity in the survey data support the median value of 1.00 RVW, in order to preserve rank order with our reference service code, the ACR recommends a value of 0.82 RVW as the work value for code 43752.

**Comparison of 43752 to Codes 44500 and 74340**

	<b>CPT code</b>	<b>RVW</b>	<b>Pre-Time</b>	<b>Intra-Time</b>	<b>Post-Time</b>	<b>Total Time</b>
<b>Reference Service code</b>						
	44500	0.49	6	25	5	36
	74340	0.54	2	30	2	34
	<b>Total</b>	<b>1.03</b>	<b>8</b>	<b>55</b>	<b>7</b>	<b>70</b>
<b>New Code</b>						
	43752	0.82	5	20	5	30

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

**FREQUENCY INFORMATION**

How was this service previously reported? CPT code 49999 (Unlisted procedure, abdomen, peritoneum and omentum). There is an interim G code (G0272) for CY 2003. (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Radiology \_\_\_\_\_ Commonly  Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiology \_\_\_\_\_ Frequency Not available

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty Radiology \_\_\_\_\_ Frequency Not available

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Living Donor Hepatectomies**

During the second five-year review, the RUC referred the donor hepatectomy issue to CPT for further consideration. As a result, the CPT Editorial Panel created three new codes to differentiate the live donor hepatectomy procedures. The live donor codes differ from the cadaver donor code in that only part of the liver is removed and this is significantly more difficult requiring additional skill. This procedure also has additional risks to a healthy volunteer donor, and is more comparable to the family of liver resection codes which are used as reference services (47120 -47136). The three new codes differ according to the amount of liver that is removed. Codes 47141 and 47142 share the same parenchymal transaction through Cantlie's line, the major fissure of the liver and, therefore, are both associated with greater effort on the part of the surgeon with greater risk to the donor. Also, these two codes require a closer dissection to the bifurcation of the portal structures associated with greater risk of complications as this dissection is more difficult due to the anatomy of both the hepatic vein and biliary tree. The liver resection codes are anatomically similar but both pieces of the liver need to be preserved. This does not allow for hilar vascular control, which is typically performed in standard resections. Therefore, this predisposes the parenchymal transection to bleeding. The need to meticulously identify and preserve vascular and biliary structures that cross the interlobar fissure mandates the use of advanced technologies for the parenchymal transaction, to minimize both bleeding and injury to the biliary and vascular structures that may need to be reconstructed.

These considerations increase the time and complexity for the procedure as compared to standard liver resections and support a higher work RVU. The RUC reviewed these three codes as a group and agreed that in comparison the liver resection codes, the new codes require more work due to the differences in dissection and the need to preserve the liver for transplantation and also to minimize blood loss of the donor and to preserve the donor's liver. Also for 47141 and 47142 repeated fluoroscopic cholangiography is always used.

The RUC compared code 47140 *Donor hepatectomy, with preparation and maintenance of allograft, from living donor; left lateral segment only (segments II and III)*, to code 47125 *Hepatectomy, resection of liver; total left lobectomy* (work RVU = 49.19) and 47122 *Hepatectomy, resection of liver; trisegmentectomy* (work RVU = 55.13) and agreed that based on the survey results and description of the additional work required for a living donor resection, the 25<sup>th</sup> percentile work RVU of 55.00 placed the code in proper rank order.

**The RUC recommends a work RVU of 55.00 for code 47140.**

The RUC compared code 47141 *Donor hepatectomy, with preparation and maintenance of allograft, from living donor; total left lobectomy (segments II, III and IV)* to code 47125 *Hepatectomy, resection of liver; total left lobectomy* (work RVU = 49.19) and 47122 *Hepatectomy, resection of liver; trisegmentectomy* (work RVU = 55.13) and code 47135 *Liver allotransplantation; orthotopic, partial or*

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

*whole, from cadaver or living donor, any age* (work RVU = 81.51) and agreed that the median RVU of 67.50 was supported by the survey data. Given the differences in time and intensity, the recommended median RVU placed the codes in proper rank order among the reference codes.

**The RUC recommends a work RVU of 67.50 for code 47141.**

The RUC compared code 471X3 *Donor hepatectomy, with preparation and maintenance of allograft, from living donor total right lobectomy (segments V, VI, VII and VIII)* to two reference codes, 47130 *Hepatectomy, resection of liver; total right lobectomy* (work RVU = 55.35) and code 47135 *Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age* (work RVU = 81.51). The RUC compared the physician time and intensity ratings of the new code to the reference codes and based on the thorough explanation of the procedure, the RUC agreed that the median recommended RVU was supported by the survey data and placed the code in proper rank order.

**The RUC recommends a work RVU of 75.00 for code 47142.**

### **Practice Expense**

The RUC examined the practice expense recommendations in great detail especially the pre-service time. The presenters described four educational sessions, each requiring two hours of clinical staff time. The RUC discussed each of the four phases that occur prior to surgery and was unable to specifically identify which phase equates to a decision for surgery. Since clinical labor activities for practice expense purposes begin after the decision for surgery is made it is important to determine when the decision is made during the donor search period. The presenters stated that during the four phases preceding the operation, they are not able to separately bill for any of the visits that relate to the donor search and meeting with the potential donors.

The presenters initially explained that they interpreted the decision for surgery to begin once the call for donors is issued and therefore the clinical labor required for all four phases should be included as a practice expense. The recommendation was revised to include four hours of clinical staff time to include phases III and IV. The RUC disagreed and as an interim measure the RUC concluded that the decision for surgery occurs after the completion of phase III. The pre-service times were reduced to only include time that would begin after phase III. Therefore, the pre-service time should include the one hour of standard pre-service time plus the two hours of pre-service education during the phase IV information session. An additional 15 minutes for significant additional atypical coordination with multiple physicians, surgeons and two patients was assigned. Also, 30 minutes for additional atypical pre-service diagnostic and referral form completion was allocated for a total pre-service time of 285 minutes. The presenters described this phase IV session as consisting of the donor and their family and the recipient and their family meeting with the physician and staff for a thorough review of the operation and risks to the donor. Every effort is made to be certain that there is no coercion from anyone and that the donor completely understands the operation, postoperative recovery, and the risks they are taking. This session is generally scheduled for two hours. Given the uncertainty of when the decision for surgery is made during the four phases that occur before

surgery, the RUC deferred to CMS and the presenters to make a final determination and adjust the pre-service times accordingly. The specialty society has provided the New York state guidelines used in donor searches and this information is attached to the recommendation.

?

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
▲47133	BB1	Donor hepatectomy, with preparation and maintenance of allograft, from cadaver donor	XXX	Carrier Priced
▲47134		partial, from living donor  (47134 has been deleted. To report, see 47140)	XXX	N/A
●47140	BB2	Donor hepatectomy, with preparation and maintenance of allograft, from living donor; left lateral segment only (segments II and III)	090	55.00
●47141	BB3	total left lobectomy (segments II, III and IV)	090	67.50
●47142	BB4	total right lobectomy (segments V, VI, VII and VIII)	090	75.00

CPT Code: 47140

Tracking No: BB2

Global: 090

Recommended RVW: 55.00  
25<sup>th</sup> percentile

**Descriptor:** Donor hepatectomy, with preparation and maintenance of allograft, from living donor; left lateral segment only (segments II and III)

---

***Organ graft recipient background information:*** An 18-month old, 10 kg, infant with biliary atresia, who underwent a Kasai procedure at three months of age, presents with significant cholestasis and signs of portal hypertension including splenomegaly, ascites, and variceal bleeding. The infant is not thriving and is below the tenth percentile in growth and weight. He requires supplemental enteral feeding. Given the infant's size, complications of the liver disease, and the infant's growth failure, it is anticipated that the waiting time that he will require on the list of potential cadaveric recipients will severely compromise the outcome of transplantation. It is the opinion of the transplant team that, given the infant's PELD score, a cadaveric organ will not be available for the infant in the near future.

***Typical Patient Vignette - Organ graft donor:*** A willing volunteer living-donor has been identified for this infant. In this particular case, it is a parent whose blood type is compatible, who has been evaluated and been found not to have any medical or psychosocial conditions that would contraindicate living donation, is free from coercion, and has been given every opportunity to decline the procedure. The anatomical data on the donor liver reveals no vascular or biliary anatomical variance that would preclude the use of the left lateral segment (Couinaud segments II and III). The volume of the left lateral segment is measured radiologically as 120 cc<sup>3</sup>, equivalent roughly to 120 gm of liver tissue [graft to body weight ratio (GBWR) is 1.2%-must exceed 0.8%]. Therefore, the left lateral segment is considered to be the graft of choice for the recipient. No hepatic steatosis is identified. To the best of the transplant team's knowledge, there is no financial compensation planned and the risks of the procedure have been thoroughly covered by the transplant team.

Once a decision has been made to proceed, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient and his/her family, and obtains informed consent. At operation, the liver is mobilized appropriately and a careful examination is made of the entire abdomen and liver to rule out any pathology that might contraindicate living donation. A donor hepatectomy, with preparation and maintenance of allograft, left lateral segment only (segments II and III) is performed. Postoperative care of the donor includes all necessary hospital and office visits through the 90-day global period.

*Note: When completing this survey, note that preparation and maintenance of the graft would include flushing and perfusion with cold preservation solution of vascular and biliary structures on the backbench, immediately upon removal from donor, and maintenance of graft in cold preservation solution. It does not include any vascular or biliary reconstructions that may be necessary for implantation.*

---

**Clinical Description Of Service:**

Note: The service includes an extensive evaluation of both donor and recipient circumstances. The decision to proceed with living donor transplantation is based on recipient characteristics in the context of existing cadaveric organ allocation policies, the lack of medical and psychosocial contraindications to transplantation, and the identification of a suitable donor.

**Pre-service work – Day before surgery**

- Write pre-operative orders for perioperative medications; Review preoperative labs, with particular attention to serologies and liver chemistries; Review preoperative films, with particular attention to radiologic imaging of vascular and biliary anatomy, as well as volume parameters; Review planned incisions and procedure; Coordinate donor procedure with recipient procedure

**Pre-service work – Day of surgery**

- Change into scrub clothes; Review the surgical procedure, postoperative recovery in and out of the hospital, and expected outcome(s) with patient and family; Answer patient and family questions and obtain informed consent; Review length and type of anesthesia with anesthesiologist; Review planned procedure and positioning and draping of patient; Verify that all necessary surgical instruments and supplies are readily available in the operative suite; Monitor patient positioning and draping, and assist with positioning as needed; Scrub and gown; The patient is positioned with the arms abducted and every effort is made to prevent brachial plexus nerve injuries; The chest and upper thighs are prepped, as well as the abdomen; The legs may need to be prepared for possible saphenous vein graft

**Intra-Service work – Skin to skin**

- A skin incision is made consisting of bilateral subcostal incisions extended to the xiphoid in the midline;
- The anterior abdominal wall is carefully divided
- The peritoneum is entered
- The round and falciform ligaments are divided
- The self-retaining mechanical retractor is secured to the operating room table and the various attachments are utilized and exposure obtained for the hepatic mobilization and resection
- A thorough exploration of the area around the liver is undertaken, including palpation and visualization of the left lateral segment
- The abdominal contents are examined for any evidence of pathology
- The left triangular ligament is taken down, exposing the left hepatic vein
- Any adhesions present are taken down by sharp and blunt dissection
- The porta hepatis is isolated and encircled with a Penrose drain
- The left hepatic artery is identified within the porta hepatis and is dissected free of the surrounding tissues and looped with a vessel loop
- The gastrohepatic ligament is taken down and great care is taken to identify any potential aberrant left hepatic arteries within the ligament
- If an artery is found, the aberrant left hepatic artery is meticulously dissected back to the junction with the left gastric artery
- The left lateral segment is reflected anteriorly and the ligamentum venosum is transected
- The round ligament is carefully dissected away from segment IV of the liver in the recess of Rex and all comeback vessels and bile ducts are transected in this plane
- Dissection is carried down to the left portal vein as the falciform remnant enters the portal vein
- The left portal vein is dissected and encircled and great care is taken not to injure the portal bifurcation
- Short caudate branches of the left portal vein are divided
- The left bile duct is identified within the liver parenchyma, preferably after the segment IV duct has entered
- The left hepatic duct is transected sharply within the liver parenchyma
- There are often multiple bile ducts and these need to be carefully identified and transected within the liver parenchyma aiming to preserve vascular supply to the bile duct and great care is taken not to injure the remaining bile duct
- The left hepatic vein is carefully dissected and, if possible, encircled within the liver parenchyma
- Intraoperative ultrasound is undertaken to locate the junction of the left and middle hepatic veins
- The ultrasound dissector is then grasped and the presumed area for resection is marked with a cautery
- The ultrasound dissector is then used to outline the area for dissection
- Individual vessels and bile ducts are identified in the depths of the ultrasonic dissection and ligated carefully with suture and divided
- Hemostasis within the liver is secured, and suture is used as necessary to repair vessels which one wishes to preserve
- The harmonic scalpel may be used in thin areas of the liver
- Hemostasis is secured in both raw surfaces making certain that there are no bile leaks

***Intra-Service work – Skin to skin (continued)***

- The argon beam coagulator may be utilized continuously on the raw surface of the liver to stop minimal oozing in an effort to prevent blood transfusion in an otherwise healthy donor thus achieving meticulous hemostasis while taking care not to coagulate bile ducts
- Once the parenchymal transection is completed and in coordination with the recipient's procedure, appropriate vascular clamps are applied to the left portal vein, left hepatic artery, and left hepatic vein and the left lateral segment is removed
- This previous step requires two additional assistants who will prepare and preserve the left lateral segment organ donation, including perfusion with cold preservation solution while the vascular and biliary stumps are carefully oversewn by the primary surgeon in the donor
- The left portal vein, left hepatic artery and left hepatic veins, and left bile duct(s) is(are) are oversewn with suture in turn
- The artery is doubly ligated with suture
- A careful check of the raw surface is carried out, assuring hemostasis and the absence of new bile leaks
- The abdominal cavity is copiously irrigated with antibiotic-laden solution
- One closed-suction drain is placed in the immediate vicinity of the resection towards the cut edge of the liver
- The position of the nasogastric tube is checked
- Perioperative antibiotics are given preoperatively, and are repeated as necessary,
- Wound towels and the retractor are removed
- The abdominal wall is closed in layered fashion
- The skin is closed in the usual fashion

**Post-op same day work through discharge from recovery**

- Apply dressings; Drainage from the drain is checked and their volume recorded; Abdominal girth is measured every six hours to make certain that bile and/or ascites is not accumulating; Check position and function of nasogastric tube; Write orders for post-op labs, films, medications, diet, and patient activity; Review recovery room care and medications with staff; Discuss procedure outcome with family; Discuss procedure outcome with patient after emergence from anesthesia; Dictate post-op report; Discuss procedure outcome with referring physician; Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company

**Post-op same day work after discharge from recovery**

- Examine patient, check wounds and patient progress; Review nursing/other staff patient chart notes; Answer patient family questions; Answer nursing/other staff questions; Write orders for following day's labs, films, medications, diet, and patient activity; Chart patient progress notes; Inform donor of recipient progress

**Post-op other hospital work – Beginning on post-op day 1, until discharge day**

- Check the drainage from right upper quadrant and record; Record abdominal girth; Continue antibiotics as indicated; Check liver chemistries every other day; Check urine output and measure urine sodium, potassium, and osmolality; Treat ascites and hypoalbumenemia as indicated; Remove nasogastric tube at appropriate time; Examine and talk with patient; Check wounds and patient progress; Discuss patient progress with referring physician (verbal and written); Review nursing/other staff patient chart notes; Answer patient/family questions; Answer nursing/other staff questions (verbal and written); Answer insurance staff questions; Write orders for post-op labs, films, medications, diet, and patient activity; Chart patient progress notes; Remove Foley catheter, check for voiding

**Discharge day work**

- Examine and talk with patient; Check wounds and patient progress; Review nursing/other staff patient chart notes; Review post-discharge wound care and activity limitations with patient; Answer patient/family questions; Answer insurance staff questions; Write orders for post-discharge labs, films, and medications; Chart patient discharge notes

**Post-op office work – After discharge from hospital**

- Examine and talk with patient; Check wounds and patient progress; Answer patient/family questions; Answer insurance staff questions; Discuss patient progress with referring physician (verbal and written); Write orders for medications; Review post-discharge labs/films (the patient's liver function is assessed to make sure that there is no evidence of hepatic insufficiency); Discuss progress with patient/family; Remove sutures/drains; Dictate patient progress notes for medical chart

**SURVEY DATA**

<b>Presenter(s):</b>	Michael Abecassis, MD, FACS; Charles Mabry, MD, FACS					
<b>Specialty(s):</b>	American Society of Transplant Surgeons; American College of Surgeons					
<b>CPT Code:</b>	471X1 (BB2)					
<b>Sample Size:</b>	130	<b>Resp n:</b>	37	<b>Resp %:</b>	28%	
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		45.00	55.00	60.00	70.00	90.00
<b>Pre-Service Evaluation Time:</b>				90		
<b>Pre-Service Positioning Time:</b>				15		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				15		
<b>Intra-Service Time:</b>		270	300	355	360	420
<b>Post-Service</b>	<b>Total Min<sup>1</sup></b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	60					
<b>Critical Care time/visit(s):</b>	82	99233* x 2			LOS = 8	
<b>Other Hospital time/visit(s):</b>	128	99233 x 1; 99232 x 1; 99231 x 3				
<b>Discharge Day Mgmt:</b>	36	99238				
<b>Office time/visit(s):</b>	84	99213 x 3; 99212 x 1				

<sup>1</sup>Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
471X1	Donor hepatectomy, with preparation and maintenance of allograft, from living donor; left lateral segment only (segments II and III)	REC 55.00	90
47125	Hepatectomy, resection of liver; total left lobectomy	49.19	90
47122	Hepatectomy, resection of liver; trisegmentectomy	55.13	90

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

	Survey CPT 471X1	Primary Ref 47125 RUC 2 <sup>nd</sup> 5yr	Survey CPT 471X1	Secondary Ref 47122 RUC 2 <sup>nd</sup> 5yr
<b>TIME ESTIMATES (MEDIAN)</b>				
Pre-service	120	75	120	75
Intra-service	355	225	355	300
Same Day Immediate Post-service	60	45	60	45
Critical care	82	126	82	189
Other hospital visit	128	210	128	210
Discharge day management	36	36	36	36
Office visit	84	61	84	61
<b>TOTAL TIME</b>	<b>865</b>	<b>778</b>	<b>865</b>	<b>916</b>

**INTENSITY/COMPLEXITY MEASURES (mean)**

<b>Survey response count</b>	13	13	9	9
<b>TIME SEGMENTS</b>				
Pre-service	4.67	3.50	4.63	4.13
Intra-service	4.83	3.83	4.75	3.88
Post-service	4.00	3.17	4.13	4.38
<b>MENTAL EFFORT AND JUDGMENT</b>				
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.58	4.22	3.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.92	3.42	4.78	4.11
Urgency of medical decision making	4.42	3.25	4.56	4.00
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>				
Technical skill required	4.92	3.75	4.78	4.33
Physical effort required	4.67	3.58	4.67	4.22
<b>PSYCHOLOGICAL STRESS</b>				
The risk of significant complications, morbidity and/or mortality	4.83	3.58	4.78	3.89
Outcome depends on the skill and judgment of physician	5.00	3.83	4.78	3.89
Estimated risk of malpractice suit with poor outcome	4.92	3.17	4.89	3.67

**ADDITIONAL RATIONALE**

The survey 25<sup>th</sup> percentile RVW of 55.00 is recommended for 471X1. The consensus committee reviewing the data chose the survey 25<sup>th</sup> percentile RVW instead of the median RVW to correctly place this service between 47125 and 47122. Compared with 47125, an RVW of 55.00 for 471X1 reflects: 1) increased intensity and complexity; 2) additional pre-operative time for team surgery and multiple patient coordination; and 3) additional intra-operative time/work for the donor procedure and for preparation and maintenance of the graft. Compared with 47122, this value reflects: 1) increased pre-op and intra-op intensity and complexity and decreased post-op intensity and complexity; 2) additional pre-operative time for team surgery and multiple patient coordination; 3) additional intra-operative time/work for the donor procedure and for preparation and maintenance of the graft; and 4) less hospital post-op time/intensity.

## **1. Discussion of time and complexity/intensity comparison**

Following is a detailed discussion of the similarities and differences between new code 471X1 and the primary reference code (47125) relative to the complexity/intensity values shown in the table above.

**Pre-service comparison:** Preoperative work for 471X1 differs markedly from that of a patient undergoing 47125. Not only must the potential donor be free of any medical or psychosocial contraindications to living donation (an essential condition required to minimize donor risk), but the status of the donor liver requires maximum attention. A preoperative knowledge and pre-operative review of the vascular and biliary anatomy is essential since often these anatomical variants will require additional efforts by the surgical team to produce a viable transplant organ.

**Intra-service technical comparison:** In the majority of cases, the biliary anatomy is not as relevant for 47125 since the bile ducts are divided in the parenchyma as they are encountered in the place of transection. In contrast, the biliary duct(s) has (have) to be identified and preserved in 471X1 and the blood supply to these ducts also must be equally preserved. This requires increased work to make sure that the transection of the duct occurs exactly at a point where it will be usable and to ensure that the duct of the donor will not be injured.

With 47125, the blood supply to the left lobe is taken early (hilar control), before parenchymal transection, so that a line of demarcation between the ischemic left lobe and the remaining viable liver guides the surgeon as to the plane of transection. One advantage of this is that typically surgeons will err slightly on the ischemic side and the parenchymal transection will be relatively bloodless given the lack of blood supply (with the exception of comeback vessels and some hepatic venous bleeding). In contrast, vascular inflow cannot be controlled in 471X1 in light of the need for a viable graft. Therefore, the parenchymal transection is performed without any type of inflow control. This results in a potentially bloody parenchymal transection and, given the important need for donor safety, including the need to avoid blood transfusion and hemodynamic instability, this requires a parenchymal transection. In order to avoid exsanguinating hemorrhage, this technique of parenchymal transection is much slower.

**Graft comparison:** Biliary complications are the Achilles' heel of living donor transplants. Therefore, attention must be paid to the preservation of a vascularized biliary tree. In 47125, the vascular supply to the biliary tree is not of concern. In 471X1, dissection is necessary to preserve the blood supply of the biliary system. This dissection is time consuming and is typically performed with high magnification loupes. Also, since the remaining stump on the donor's bile duct is typically short, careful oversewing of this stump is essential in ensuring donor safety and preventing biliary leakage in the donor. This is in contrast to ligation and division of whatever biliary structures are encountered during 47125.

**Technical skill comparison:** The performance of living donor liver transplantation requires significant knowledge and training. When performed in children, the procedure is typically performed either by a pediatric surgeon who has received additional training in transplant surgery or by a transplant surgeon who has received additional training in pediatric surgery. Both groups undergo training in ASTS-accredited programs. When performed in adults, this procedure is performed by a transplant surgeon who likewise has undergone training in an ASTS-accredited program. The ASTS accreditation standards for transplant surgery fellowship programs require that each fellow must perform at least 45 liver transplants over the course of his or her fellowship.

**Stress comparison:** The level of stress involved in operating on an otherwise healthy individual compounds the usual level of stress associated with major surgical procedures. Although the recipients derive direct benefit from the transplant, it is difficult to assign any physical benefit to the donor. This fact adds tremendously to the process of informed consent for 471X1 and makes a benefit-to-risk analysis impossible from the donor's perspective. These concepts must be continuously communicated to the donor and his or her family and to those clinical professionals involved in the provision of healthcare to the donor.

## **2. IWPUT Analysis**

The following IWPUT analysis using the Building Block Methodology is provided to show that the 25<sup>th</sup> pct IWPOT for new code 471X1 is reasonably similar to the reference services. This analysis is another way to compare procedures in the same family with different time and visit patterns for pre- and post-service work. This analysis also allows for differences in intraoperative time. It is another way to show that the 25<sup>th</sup> percentile survey RVW of 55.00 for 471X1 is reasonable compared with 47125 and 47122.

**IWPUT Analysis**

ROW / COLUMN	A	B	C
1	<b>471X1(25<sup>th</sup> pctl)</b>	<b>471X1</b>	<b>Svy RVW: 55.00</b>
2	<b>and 47125</b>	<b>Svy Data</b>	<b>RUC Std. RVW</b>
3	<b>Pre-service:</b>	<b>Time</b>	<b>Intensity (=time x ints'y)</b>
4	Pre: eval & posit	105	0.0224 2.35
5	Pre: scrub,dress,wait	15	0.0081 0.12
6	<b>Pre-service total</b>	<b>2.47</b>	
7	<b>Post-service:</b>	<b>Time</b>	<b>Intensity (=time x ints'y)</b>
8	Immediate post	60	0.0224 1.34
9	<b>Subsequent visits:</b>	<b>Visit n</b>	<b>E/M RVW (=n x RVW)</b>
10	ICU 99291		4.00
11	99233	3	1.51 4.53
12	99232	1	1.06 1.06
13	99231	3	0.64 1.92
14	Discharge 99238	1	1.28 1.28
15	Discharge 99239		1.75
16	99214		1.08
17	99213	3	0.65 1.95
18	99212	1	0.43 0.43
19	99211		0.17
20	<b>Post-service total</b>	<b>12.51</b>	
21	<b>Intra-service:</b>	<b>Time</b>	<b>IWPUT INTRA-RVW</b>
22	<b>Intra total</b>	<b>355</b>	<b>0.113 40.01</b>

D	E	F
<b>47125</b>	<b>MFS RVW:</b>	<b>49.19</b>
<b>Svy Data</b>	<b>RUC Std.</b>	<b>RVW</b>
<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>
50	0.0224	1.12
25	0.0081	0.20
		<b>1.32</b>
<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>
45	0.0224	1.01
<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>
2	4.00	8.00
2	1.51	3.02
3	1.06	3.18
2	0.64	1.28
1	1.28	1.28
		1.75
		1.08
2	0.65	1.30
1	0.43	0.43
		0.17
		<b>19.50</b>
<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>
<b>225</b>	<b>0.126</b>	<b>28.37</b>

ROW / COLUMN	A	B	C
1	<b>471X1 (25<sup>th</sup> pctl)</b>	<b>471X1</b>	<b>Svy RVW: 55.00</b>
2	<b>and 47122</b>	<b>Svy Data</b>	<b>RUC Std. RVW</b>
3	<b>Pre-service:</b>	<b>Time</b>	<b>Intensity (=time x ints'y)</b>
4	Pre: eval & posit	105	0.0224 2.35
5	Pre: scrub,dress,wait	15	0.0081 0.12
6	<b>Pre-service total</b>	<b>2.47</b>	
7	<b>Post-service:</b>	<b>Time</b>	<b>Intensity (=time x ints'y)</b>
8	Immediate post	60	0.0224 1.34
9	<b>Subsequent visits:</b>	<b>Visit n</b>	<b>E/M RVW (=n x RVW)</b>
10	ICU 99291		4.00
11	99233	3	1.51 4.53
12	99232	1	1.06 1.06
13	99231	3	0.64 1.92
14	Discharge 99238	1	1.28 1.28
15	Discharge 99239		1.75
16	99214		1.08
17	99213	3	0.65 1.95
18	99212	1	0.43 0.43
19	99211		0.17
20	<b>Post-service total</b>	<b>12.51</b>	
21	<b>Intra-service:</b>	<b>Time</b>	<b>IWPUT INTRA-RVW</b>
22	<b>Intra total</b>	<b>355</b>	<b>0.113 40.01</b>

D	E	F
<b>47122</b>	<b>MFS RVW:</b>	<b>55.13</b>
<b>Svy Data</b>	<b>RUC Std.</b>	<b>RVW</b>
<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>
50	0.0224	1.12
25	0.0081	0.20
		<b>1.32</b>
<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>
45	0.0224	1.01
<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>
3	4.00	12.00
2	1.51	3.02
3	1.06	3.18
2	0.64	1.28
1	1.28	1.28
		1.75
		1.08
2	0.65	1.30
1	0.43	0.43
		0.17
		<b>23.50</b>
<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>
<b>300</b>	<b>0.101</b>	<b>30.31</b>

**3. Additional NOTE about work prior to the day before surgery**

As noted in the cover letter accompanying this Summary Form, multiple potential donors are evaluated prior to selecting a donor for a liver transplantation. The services provided to potential donors include information sessions and face-to-face explanations of risks and benefits. The level of work that goes into the identification of a suitable donor is quite extensive and is not compensated, since no service is rendered to the individuals who do not donate. The time and work associated with these services is NOT included in the recommended RVW for 471X1.

---

**Services Reported with Multiple CPT Codes**

To be provided under separate cover.

---

**FREQUENCY INFORMATION****How was this service previously reported?**

47134 – This (to be deleted) code has an XXX global period with a value based on 1994 RUC facilitation of a number of new transplant procedures. Additionally, this code was not included with the family of hepatectomy codes (47XXX) that were reviewed and increased during the second five-year review because the codes were undergoing the CPT process.

**How often do physicians in your specialty perform this service?**

Specialty: transplant surgery                      ~~Commonly~~                      Sometimes                      Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: transplant surgery

Frequency: Utilization data available from the United Network for Organ Sharing (UNOS) indicate that, for the years 1996 – 2000, there were 374 pediatric living donor transplants (average = 75 each year).

**For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?**

Specialty: transplant surgery                      Frequency: N/A

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

---

CPT Code: 47141 Tracking No: BB3 Global: 090

Recommended RVW: 67.50

**Descriptor:** Donor hepatectomy, with preparation and maintenance of allograft, from living donor; total left lobectomy (segments II, III and IV)

---

***Organ graft recipient background information:*** A 7 y.o., 35 kg, child presents with acute onset liver failure of unclear etiology, although autoimmune hepatitis is suspected from the transjugular biopsy. The patient has been receiving steroid therapy without improvement. This child has now met both King's College and Clichy criteria for transplantation. The child has grade III encephalopathy, a marked prolonged INR, with a non-A, non-B etiology, and a high bilirubin. In addition, factor V has been decreasing and there are three measurements below 25 percent. The child is beginning to exhibit evidence of type I hepatorenal syndrome, although it is expected that the kidneys will recover following liver transplantation. The child has been listed on the cadaver waiting list for 24 hours and there have been no liver offers. Her condition is rapidly deteriorating and there is concern about impending cerebral edema. The arterial ammonia level is 200. The child is intubated and ventilated.

***Typical Patient Vignette - Organ graft donor:*** One of the child's parents is available as a potential living donor. The parent's blood type is compatible. The parent has been evaluated and been found to not have any medical or psychosocial conditions that would contraindicate living donation, is free from coercion, and has been given every opportunity to decline the procedure. The anatomical data on the donor liver reveals no vascular or biliary anatomical variance that would preclude the use of the left lobe (Couinaud segments II, III, and IV). The volume of the left lateral segment is measured radiologically as 350 cc<sup>3</sup>, equivalent roughly to 350 gm of liver tissue [graft to body weight ratio (GBWR) is 1.0%-must exceed 0.8%]. The left lateral segment (segments II and III) measure 170 cc<sup>3</sup> (0.5%), which does not provide adequate liver mass for the child. Therefore, the left lobe is considered to be the graft of choice for this particular recipient. No hepatic steatosis was identified. To the best of the transplant team's knowledge, there is no financial compensation planned and the risks of the procedure have been thoroughly explained by the transplant team to the parent. Although the patient is listed as a status 1 and despite mandatory regional sharing, there is concern by the transplant team and the child's parents that a suitable organ will not be identified and procured before the onset of irreversible brain damage secondary to cerebral edema. Since the potential donor has been preemptively evaluated and approved, the decision is made to proceed urgently with living donor liver transplantation. It is assumed that if, in the process of preparing the donor for hepatectomy, a suitable cadaveric donor is in fact identified and the time interval required to procure the organ is reasonable, the living donor procedure will be abandoned in favor of a cadaveric transplant.

Once a decision has been made to proceed, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient and his/her family, and obtains informed consent. At operation, the liver is mobilized appropriately and a careful examination is made of the entire abdomen and liver to rule out any pathology that might contraindicate living donation. A donor hepatectomy, with preparation and maintenance of allograft, total left lobectomy (segments II, III and IV) is performed. Postoperative care of the donor includes all necessary hospital and office visits through the 90-day global period.

*When completing this survey, note that preparation and maintenance of the graft would include flushing and perfusion with cold preservation solution of vascular and biliary structures on the backbench, immediately upon removal from donor, and maintenance of graft in cold preservation solution. It does not include any vascular or biliary reconstructions that may be necessary for implantation.*

---

**Clinical Description Of Service:**

Note: The service includes an extensive evaluation of both donor and recipient circumstances. The decision to proceed with living donor transplantation is based on recipient characteristics in the context of existing cadaveric organ allocation policies, the lack of medical and psychosocial contraindications to transplantation, and the identification of a suitable donor.

**Pre-service work – Day before surgery**

- Write pre-operative orders for perioperative medications; Review preoperative labs, with particular attention to serologies and liver chemistries; Review preoperative films, with particular attention to radiologic imaging of vascular and biliary anatomy, as well as volume parameters; Review planned incisions and procedure; Coordinate donor procedure with recipient procedure

**Pre-service work – Day of surgery**

- Change into scrub clothes; Review the surgical procedure, postoperative recovery in and out of the hospital, and expected outcome(s) with patient and family; Answer patient and family questions and obtain informed consent; Review length and type of anesthesia with anesthesiologist; Review planned procedure and positioning and draping of patient; Verify that all necessary surgical instruments and supplies are readily available in the operative suite; Monitor patient positioning and draping, and assist with positioning as needed; Scrub and gown; The patient is positioned with the arms abducted and every effort is made to prevent brachial plexus nerve injuries; The chest and upper thighs are prepped, as well as the abdomen; The legs may need to be prepared for possible saphenous vein graft

**Intra-Service work – Skin to skin**

- A skin incision is made consisting of bilateral subcostal incisions extended to the xiphoid in the midline
- The anterior abdominal wall is carefully divided
- The peritoneum is entered
- The round and falciform ligaments are divided
- The self-retaining mechanical retractor is secured to the operating room table and the various attachments are utilized and exposure obtained for the hepatic mobilization and resection
- A thorough exploration of the area around the liver is undertaken, including palpation and visualization of the left lobe
- The abdominal contents are examined for any evidence of pathology
- The left triangular ligament is taken down, exposing the left and middle hepatic veins
- Any adhesions present are taken down by sharp and blunt dissection
- The porta hepatis is isolated and encircled with a Penrose drain
- The left hepatic artery is identified within the porta hepatis and is dissected free of the surrounding tissues and looped with a vessel loop
- The gastrohepatic ligament is taken down and great care is taken to identify any potential aberrant left hepatic arteries within the ligament
- If an artery is found, the aberrant left hepatic artery is meticulously dissected back to the junction with the left gastric artery
- Dissection is carried down to the left portal vein
- The left portal vein is meticulously dissected and encircled and great care is taken not to injure the portal bifurcation
- Short caudate branches of the left portal vein are divided
- If the caudate lobe is included with the left lobe, the caudate veins are identified and the major ones spared for reimplantation
- The left bile duct is identified at the base of segment IV
- A cholecystectomy is preformed and a cystic duct cholangiogram catheter inserted into the cystic duct for fluoroscopic cholangiography
- The biliary anatomy is confirmed with cholangiography

***Intra-Service work – Skin to skin (continued)***

- The left hepatic duct is transected sharply away from the main confluence
- There are often multiple bile ducts and these need to be carefully identified and transected within the liver parenchyma aiming to preserve vascular supply to the bile duct and great care is taken not to injure the remaining bile duct
- The left and middle hepatic veins are carefully dissected and, if possible, encircled within the liver parenchyma
- Intraoperative ultrasound is undertaken to locate the junction of the left and middle hepatic veins
- The ultrasound dissector is then grasped and the presumed area for resection is marked with a cautery
- The ultrasound dissector is then used to outline the area for dissection (Cantlie's line – major hepatic fissure)
- Individual vessels and bile ducts are identified in the depths of the ultrasonic dissection and ligated carefully with suture and divided
- Hemostasis within the liver is secured and prolene is used as necessary to repair vessels which one wishes to preserve
- The harmonic scalpel is used in thin areas of the liver
- Hemostasis is secured in both raw surfaces making certain that there are no bile leaks
- The argon beam coagulator is utilized continuously on the raw surface of the liver to stop minimal oozing in an effort to prevent blood transfusion in an otherwise healthy donor thus achieving meticulous hemostasis while taking care not to coagulate bile ducts
- Once the parenchymal transection is completed and in coordination with the recipient's procedure, appropriate vascular clamps are applied to the left portal vein, left hepatic artery, and left hepatic vein and the left lobe is removed
- This requires two additional assistants who will prepare and preserve the left lobe including perfusion with cold preservation solution while the vascular and biliary stumps are carefully oversewn in the donor
- The left portal vein, left hepatic artery and left and middle hepatic veins are oversewn with Prolene
- The artery is doubly ligated with suture and the left bile duct(s) is (are) oversewn with Prolene
- A careful check of the raw surface is carried out, looking for meticulous hemostasis and the absence of new bile leaks
- A completion cholangiogram is performed to document the integrity of the remaining bile duct system and to check for leaks. The catheter is removed and the cystic duct is doubly ligated
- The abdominal cavity is copiously irrigated with antibiotic-laden solution
- One closed-suction drain is placed in the immediate vicinity of the resection towards the cut edge of the liver
- The position of the nasogastric tube is checked
- Perioperative antibiotics are given preoperatively, but are repeated as necessary, depending on time intraoperatively; thus if a first-generation cephalosporin is used, a redosing occurs at two hours following the initial dose
- Wound towels and the retractor are removed; The abdominal wall is closed in layered fashion with meticulous attention to hemostasis; The skin is closed in the usual fashion

**Post-op same day work through discharge from recovery**

- Apply dressings; Drainage from the drain is checked and their volume recorded; Abdominal girth is measured every six hours to make certain that bile and/or ascites is not accumulating; Check position and function of nasogastric tube; Write orders for post-op labs, films, medications, diet, and patient activity; Review recovery room care and medications with staff; Discuss procedure outcome with family; Discuss procedure outcome with patient after emergence from anesthesia; Dictate post-op report; Discuss procedure outcome with referring physician; Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company

**Post-op same day work after discharge from recovery**

- Examine patient, check wounds and patient progress; Review nursing/other staff patient chart notes; Answer patient family questions; Answer nursing/other staff questions; Write orders for following day's labs, films, medications, diet, and patient activity; Chart patient progress notes; Inform donor of recipient progress

**Post-op other hospital work – Beginning on post-op day 1, until discharge day**

- Check the drainage from right upper quadrant and record; Record abdominal girth; Continue antibiotics as indicated; Check liver chemistries every other day; Check urine output and measure urine sodium, potassium, and osmolality; Treat ascites and hypoalbuminemia as indicated; Remove nasogastric tube at appropriate time; Examine and talk with patient; Check wounds and patient progress; Discuss patient progress with referring physician (verbal and written); Review nursing/other staff patient chart notes; Answer patient/family questions; Answer nursing/other staff questions (verbal and written); Answer insurance staff questions; Write orders for post-op labs, films, medications, diet, and patient activity; Chart patient progress notes; Remove Foley catheter, check for voiding

#### Discharge day work

- Examine and talk with patient; Check wounds and patient progress; Review nursing/other staff patient chart notes; Review post-discharge wound care and activity limitations with patient; Answer patient/family questions; Answer insurance staff questions; Write orders for post-discharge labs, films, and medications; Chart patient discharge notes

#### Post-op office work – After discharge from hospital

- Examine and talk with patient; Check wounds and patient progress; Answer patient/family questions; Answer insurance staff questions; Discuss patient progress with referring physician (verbal and written); Write orders for medications; Review post-discharge labs/films (the patient's liver function is assessed to make sure that there is no evidence of hepatic insufficiency); Discuss progress with patient/family; Remove sutures/drains; Dictate patient progress notes for medical chart

#### SURVEY DATA

<b>Presenter(s):</b>	Michael Abecassis, MD, FACS; Charles Mabry, MD, FACS				
<b>Specialty(s):</b>	American Society of Transplant Surgeons; American College of Surgeons				
<b>CPT Code:</b>	471X2 (BB3)				
<b>Sample Size:</b>	130	<b>Resp n:</b>	37	<b>Resp %:</b>	28%
<b>Sample Type:</b>	Random				
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		55.00	60.00	67.50	80.38
<b>Pre-Service Evaluation Time:</b>				105	
<b>Pre-Service Positioning Time:</b>				15	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				15	
<b>Intra-Service Time:</b>		300	360	420	480
<b>Post-Service</b>	<b>Total Min<sup>1</sup></b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	60				
<b>Critical Care time/visit(s):</b>	82	99233* x 2			LOS = 10
<b>Other Hospital time/visit(s):</b>	188	99233 x 2; 99232 x 1; 99231 x 4			
<b>Discharge Day Mgmt:</b>	36	99238			
<b>Office time/visit(s):</b>	107	99213 x 4; 99212 x 1			

<sup>1</sup>Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
471X2	<i>Donor hepatectomy, with preparation and maintenance of allograft, from living donor; total left lobectomy (segments II, III and IV)</i>	REC 67.50	90
47125	Hepatectomy, resection of liver; total left lobectomy	49.19	90
47135	Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age	81.51	90

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

	Svy CPT 471X2	Primary Ref 47125 RUC 2 <sup>nd</sup> 5yr	Svy CPT 471X2	Secondary Ref 47135 RUC Feb94
<b>TIME ESTIMATES (MEDIAN)</b>				
Pre-service	135	75	135	120
Intra-service	420	225	420	520
Same Day Immediate Post-service	60	45	60	700
Critical care	82	126	82	
Other hospital visit	188	210	188	
Discharge day management	36	36	36	
Office visit	107	61	107	161
<b>TOTAL TIME</b>	<b>1,028</b>	<b>778</b>	<b>1,028</b>	<b>1,501</b>
<b>INTENSITY/COMPLEXITY MEASURES (mean)</b>				
Survey response count	10	10	12	12
<b>TIME SEGMENTS</b>				
Pre-service	4.88	3.38	4.91	4.36
Intra-service	5.00	3.63	5.00	4.45
Post-service	4.50	3.25	4.50	4.36
<b>MENTAL EFFORT AND JUDGMENT</b>				
The number of possible diagnosis and/or the number of management options that must be considered	3.78	3.33	4.58	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.89	3.22	4.92	4.00
Urgency of medical decision making	4.33	3.11	4.58	4.08
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>				
Technical skill required	5.00	3.67	5.00	4.58
Physical effort required	4.89	3.56	4.92	4.50
<b>PSYCHOLOGICAL STRESS</b>				
The risk of significant complications, morbidity and/or mortality	4.89	3.44	5.00	4.25
Outcome depends on the skill and judgment of physician	4.89	3.67	5.00	4.17
Estimated risk of malpractice suit with poor outcome	4.78	2.89	4.83	4.08

**ADDITIONAL RATIONALE**

The survey median RVW of 67.50 is being recommended for 471X2. Compared with 47125, an RVW of 67.50 for 471X2 reflects: 1) increased intensity and complexity; 2) additional pre-operative time for team surgery and multiple patient coordination; and 3) additional intra-operative time/work for the donor procedure and for preparation and maintenance of the graft. Relative to 47135, the median RVW is well below 81.51 which reflects less intra-operative and post-operative time. The pre-, intra-, and post-op intensities for 471X2 and 47135 are very similar.

## **1. Discussion of time and complexity/intensity comparison**

Following is a detailed discussion of the similarities and differences between new code 471X2 and the primary reference code (47125) relative to the complexity/intensity values shown in the table above.

**Pre-service comparison:** Preoperative work for 471X2 differs markedly from that of a patient undergoing 47125. Not only must the potential donor be free of any medical or psychosocial contraindications to living donation (an essential condition required to minimize donor risk), but the status of the donor liver requires maximum attention. A preoperative knowledge and pre-operative review of the vascular and biliary anatomy is essential since often these anatomical variants will require additional efforts by the surgical team to produce a viable transplant organ.

**Intra-service technical comparison:** In the majority of cases, the biliary anatomy is not as relevant for 47125 since the bile ducts are divided in the parenchyma as they are encountered in the place of transection. In contrast, the biliary duct(s) has (have) to be identified and preserved in 471X2 and the blood supply to these ducts also must be equally preserved. This requires increased work to make sure that the transection of the duct occurs exactly at a point where it will be usable and to ensure that the duct of the donor will not be injured.

With 47125, the blood supply to the left lobe is taken early (hilar control), before parenchymal transection, so that a line of demarcation between the ischemic left lobe and the remaining viable liver guides the surgeon as to the plane of transection. One advantage of this is that typically surgeons will err slightly on the ischemic side and the parenchymal transection will be relatively bloodless given the lack of blood supply (with the exception of comeback vessels and some hepatic venous bleeding). In contrast, vascular inflow cannot be controlled in 471X2 in light of the need for a viable graft. Therefore, the parenchymal transection is performed without any type of inflow control. This results in a potentially bloody parenchymal transection and, given the important need for donor safety, including the need to avoid blood transfusion and hemodynamic instability, this requires a parenchymal transection. In order to avoid exsanguinating hemorrhage, this technique of parenchymal transection is much slower.

**Graft comparison:** Biliary complications are the Achilles' heel of living donor transplants. Therefore, attention must be paid to the preservation of a vascularized biliary tree. In 47125, the vascular supply to the biliary tree is not of concern. In 471X2, dissection is necessary to preserve the blood supply of the biliary system. This dissection is time consuming and is typically performed with high magnification loupes. Also, since the remaining stump on the donor's bile duct is typically short, careful oversewing of this stump is essential in ensuring donor safety and preventing biliary leakage in the donor. This is in contrast to ligation and division of whatever biliary structures are encountered during 47125.

**Technical skill comparison:** The performance of living donor liver transplantation requires significant knowledge and training. When performed in children, the procedure is typically performed either by a pediatric surgeon who has received additional training in transplant surgery or by a transplant surgeon who has received additional training in pediatric surgery. Both groups undergo training in ASTS-accredited programs. When performed in adults, this procedure is performed by a transplant surgeon who likewise has undergone training in an ASTS-accredited program. The ASTS accreditation standards for transplant surgery fellowship programs require that each fellow must perform at least 45 liver transplants over the course of his or her fellowship.

**Stress comparison:** The level of stress involved in operating on an otherwise healthy individual compounds the usual level of stress associated with major surgical procedures. Although the recipients derive direct benefit from the transplant, it is difficult to assign any physical benefit to the donor. This fact adds tremendously to the process of informed consent for 471X2 and makes a benefit-to-risk analysis impossible from the donor's perspective. These concepts must be continuously communicated to the donor and his or her family and to those clinical professionals involved in the provision of healthcare to the donor.

**2. IWPUT Analysis**

The following IWPUT analysis using the Building Block Methodology is provided to show that the IWPUT for new code 471X2 is reasonably similar to 47125. [It is also similar to 471X1, which has an IWPUT of 0.113 based on the recommended RVW of 55.00.] This analysis is another way to compare procedures in the same family with different time and visit patterns for pre- and post-service work. This analysis also allows for differences in intraoperative time. It is another way to show that the median survey RVW of 67.50 for 471X2 is reasonable when compared with 47125 and 471X1. Note: An IWPUT comparison with 47135 cannot be performed. This code was surveyed in 1993, using a previous version of the RUC survey that did not include details for postoperative visits.

**IWPUT ANALYSIS**

ROW / COLUMN	A	B	C	D	E	F	
1	<b>471X2 and</b>	<b>471X2</b>	<b>Svy RVW:</b>	<b>67.50</b>	<b>47125</b>	<b>MFS RVW:</b>	<b>49.19</b>
2	<b>47125</b>	<b>Svy Data</b>	<b>RUC Std.</b>	<b>RVW</b>	<b>Svy Data</b>	<b>RUC Std.</b>	<b>RVW</b>
3	<b>Pre-service:</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>
4	Pre: eval & posit	120	0.0224	2.69	50	0.0224	1.12
5	Pre: scrub,dress,wait	15	0.0081	0.12	25	0.0081	0.20
6	<b>Pre-service total</b>			<b>2.81</b>			<b>1.32</b>
7	<b>Post-service:</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>
8	Immediate post	60	0.0224	1.34	45	0.0224	1.01
9	<b>Subsequent visits:</b>	<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>	<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>
10	ICU 99291		4.00		2	4.00	8.00
11	99233	4	1.51	6.04	2	1.51	3.02
12	99232	1	1.06	1.06	3	1.06	3.18
13	99231	4	0.64	2.56	2	0.64	1.28
14	Discharge 99238	1	1.28	1.28	1	1.28	1.28
15	Discharge 99239		1.75			1.75	
16	99215		1.73			1.73	
17	99214		1.08			1.08	
18	99213	4	0.65	2.60	2	0.65	1.30
19	99212	1	0.43	0.43	1	0.43	0.43
20	99211		0.17			0.17	
21	<b>Post-service total</b>			<b>15.31</b>			<b>19.50</b>
22	<b>Intra-service:</b>	<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>	<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>
23	<b>Intra total</b>	<b>420</b>	<b>0.118</b>	<b>49.38</b>	<b>225</b>	<b>0.126</b>	<b>28.37</b>

**3. Additional NOTE about work prior to the day before surgery**

As noted in the cover letter accompanying this Summary Form, multiple potential donors are evaluated prior to selecting a donor for a liver transplantation. The services provided to potential donors include information sessions and face-to-face explanations of risks and benefits. The level of work that goes into the identification of a suitable donor is quite extensive and is not compensated, since no service is rendered to the individuals who do not donate. The time and work associated with these services is NOT included in the recommended RVW for 471X2.

**Services Reported with Multiple CPT Codes**

To be provided under separate cover.

**FREQUENCY INFORMATION****How was this service previously reported?**

47399 Unlisted procedure, liver

The following two codes *may* also have been used, but are *not accurate* for this new procedure:

47134 Donor hepatectomy, with preparation and maintenance of allograft; partial, from living donor

47125 Hepatectomy, resection of liver; total left lobectomy

**How often do physicians in your specialty perform this service?**

Specialty: transplant surgery                      Commonly              Sometimes              Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: transplant surgery

Frequency: The precise utilization of this procedure is not known. The recipients of this type of living donor transplant are typically older children (i.e. at least five years of age) and small adults. Utilization data available from the United Network for Organ Sharing (UNOS) indicates that between 1990 and 2001, there were 52,022 liver transplants in the United States of which approximately 1,547 (about 3%) involved living donors. There is no reported data, however, on what percentage of living donor transplants involve transplantation of the entire left lobe. As discussed above, the recipients of left lobe transplants include both larger children and small adults. ASTS estimates that these procedures account for approximately 30% of all pediatric living donor transplants. (Pediatric patients represent about 10% of total liver transplant recipients but a somewhat higher percentage of living donor transplant recipients). The number of adults for whom a left lobe transplant is appropriate is not known; however, adults generally require right lobe transplants, and left lobe transplants involving adult recipients are relatively uncommon.

**For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?**

Specialty: transplant surgery                      Frequency: unable to estimate

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

CPT Code: 47142 Tracking No: BB4 Global: 090

Recommended RVW: 75.00

**Descriptor:** Donor hepatectomy, with preparation and maintenance of allograft, from living donor; total right lobectomy (segments V, VI, VII and VIII)

---

**Organ graft recipient background information:** A 37-year-old, 70 kg male with primary sclerosing cholangitis presents with recurrent episodes of cholangitis, a dominant stricture in the common hepatic duct (CHD), as well as significant stricture in both right and left ducts. These strictures have failed repeated endoscopic therapy. Brushings from the dominant CHD stricture reveal severe dysplasia. The patient has failed long-term antibiotic prophylaxis. A liver biopsy reveals cirrhosis and the patient has evidence of mild to moderate portal hypertension including splenomegaly and grade I to II esophageal varices. The patient's CA19-9 is slightly elevated with a value of 58, but repeated imaging studies of the liver do not reveal radiologic evidence of cholangiocarcinoma. The patient has intact renal function and his synthetic function is mildly disrupted (albumin 3.0, INR 1.1). The patient's MELD score places him at a significant disadvantage on the cadaveric waiting list. A request for consideration as a "special case" has been turned down by the Regional Review Board. There is no reason to believe that his MELD score will increase over the next 12 to 18 months and there is a reasonable likelihood that the patient will continue to deteriorate. Given the severity of his recurrent episodes of cholangitis, there is serious concern about life-threatening infection in the setting of cirrhosis with portal hypertension and synthetic dysfunction. There are no other surgical alternatives to this patient's management. Specifically, surgical biliary bypass is not possible given both the location of the strictures and the presence of portal hypertension. Furthermore, the patient has failed dilatation and stenting on repeated occasions and worsening of his portal hypertension is anticipated. Finally, given the severe dysplastic nature of his brushings, the risk of development of cholangiocarcinoma is considered, as is the fact that cholangiocarcinoma, if detected, may contraindicate liver transplantation.

**Typical Patient Vignette - Organ graft donor:** The patient's brother has volunteered to be a living donor. This is a healthy 35-year-old male with no significant past medical history. His blood type is compatible. He has been evaluated and been found not to have any medical or psychosocial conditions that would contraindicate living donation, is free from coercion, and has been given every opportunity to decline the procedure. The anatomical data on the donor liver reveals a few vascular and biliary anatomical variances, including a trifurcation of the portal vein, as well as a trifurcation of the bile duct. (Two other potential donors have been evaluated and ruled out for medical and anatomical reasons.) The volume of the right lobe is measured radiologically as 860 cc<sup>3</sup>, equivalent roughly to 860 gm of liver tissue (graft to body weight ratio (GBWR) is 1.2%-must exceed 0.8%). The left lobe (segments II, III, and IV) measures 420 cc<sup>3</sup> (0.6%) and, therefore, the left lobe does not provide adequate liver mass for the patient. Therefore, the right lobe is considered to be the graft of choice for this particular recipient. No hepatic steatosis was identified. To the best of the transplant team's knowledge, there is no financial compensation planned and the risks of the procedure have been thoroughly covered by the transplant team.

Once a decision has been made to proceed, the surgeon reviews laboratory and x-ray/imaging studies to plan the operative approach, discusses the procedure with the patient and his/her family, and obtains informed consent. At operation, the liver is mobilized appropriately and a careful examination is made of the entire abdomen and liver to rule out any pathology that might contraindicate living donation. A donor hepatectomy, with preparation and maintenance of allograft, total right lobectomy (segments V, VI, VII and VIII) is performed. Postoperative care of the donor includes all necessary hospital and office visits through the 90-day global period.

*When completing this survey, note that preparation and maintenance of the graft would include flushing and perfusion with cold preservation solution of vascular and biliary structures on the backbench, immediately upon removal from donor, and maintenance of graft in cold preservation solution. It does not include any vascular or biliary reconstructions that may be necessary for implantation.*

---

**Clinical Description Of Service:**

Note: The service includes an extensive evaluation of both donor and recipient circumstances. The decision to proceed with living donor transplantation is based on recipient characteristics in the context of existing cadaveric organ allocation policies, the lack of medical and psychosocial contraindications to transplantation, and the identification of a suitable donor.

**Pre-service work – Day before surgery**

- Write pre-operative orders for perioperative medications; Review preoperative labs, with particular attention to serologies and liver chemistries; Review preoperative films, with particular attention to radiologic imaging of vascular and biliary anatomy, as well as volume parameters; Review planned incisions and procedure; Coordinate donor procedure with recipient procedure

**Pre-service work – Day of surgery**

- Change into scrub clothes; Review the surgical procedure, postoperative recovery in and out of the hospital, and expected outcome(s) with patient and family; Answer patient and family questions and obtain informed consent; Review length and type of anesthesia with anesthesiologist; Review planned procedure and positioning and draping of patient; Verify that all necessary surgical instruments and supplies are readily available in the operative suite; Monitor patient positioning and draping, and assist with positioning as needed; Scrub and gown; The patient is positioned with the arms abducted and every effort is made to prevent brachial plexus nerve injuries; The chest and upper thighs are prepped, as well as the abdomen; The legs may need to be prepared for possible saphenous vein graft

**Intra-Service work – Skin to skin**

- A skin incision is made consisting of bilateral subcostal incisions extended to the xiphoid in the midline
- The anterior abdominal wall is carefully divided
- The peritoneum is entered
- The round and falciform ligaments are divided
- The self-retaining mechanical retractor is secured to the operating room table and the various attachments are utilized and exposure obtained for the hepatic mobilization and resection
- A thorough exploration of the area around the liver is undertaken, including palpation and visualization of the right lobe
- The abdominal contents are examined for any evidence of pathology
- The right triangular, right coronary, and right hepatorenal ligaments are taken down, exposing the “bare area” which is then dissected to the inferior vena cava
- Any adhesions present are taken down by sharp and blunt dissection
- The porta hepatis is isolated and encircled with a Penrose drain
- The right hepatic artery is identified within the porta hepatis and is dissected free of the surrounding tissues and looped with a vessel loop
- A cholecystectomy is performed and a cystic duct cholangiogram catheter inserted into the cystic duct for fluoroscopic cholangiography
- The biliary anatomy is confirmed with cholangiography
- Dissection is carried down to the right portal vein
- The right portal vein is dissected and encircled and great care is taken not to injure the portal bifurcation
- Short caudate branches of the right portal vein are divided
- The right bile duct(s) is(are) identified by lowering the hilar plate
- The right hepatic duct is transected sharply within the liver parenchyma
- There are often multiple bile ducts and these need to be carefully identified and transected within the liver parenchyma aiming to preserve vascular supply to the bile duct and great care is taken not to injure the remaining bile duct

***Intra-Service work – Skin to skin (continued)***

- The caudate lobe is mobilized from the inferior vena cava by dividing all caudate and accessory hepatic veins. These are individually ligated
- The right hepatic vein is carefully dissected and, if possible, encircled within the liver parenchyma
- Intraoperative ultrasound is undertaken to locate the junction of the right and middle hepatic veins
- The ultrasound dissector is then grasped and the presumed area for resection is marked with a cautery
- The ultrasound dissector is then used to outline the area for dissection along Cantlie's line (major hepatic fissure)
- Individual vessels and bile ducts are identified in the depths of the ultrasonic dissection and ligated carefully with suture and divided
- Hemostasis within the liver is secured and Prolene is used as necessary to repair vessels which one wishes to preserve
- Hepatic veins draining segments V and VIII are spared for future reimplantation
- Hemostasis is secured in both raw surfaces making certain that there are no bile leaks
- The argon beam coagulator is utilized continuously on the raw surface of the liver to stop minimal oozing in an effort to prevent blood transfusion in an otherwise healthy donor thus achieving hemostasis while taking care not to coagulate bile ducts
- Once the parenchymal transection is completed and in coordination with the recipient's procedure, appropriate vascular clamps are applied to the right portal vein, right hepatic artery, and right hepatic vein and the right lobe is removed
- This requires two additional assistants who will prepare and preserve the right lobe including perfusion with cold preservation solution while the vascular and biliary stumps are carefully oversewn in the donor
- The right portal vein, right hepatic artery, and right hepatic vein are oversewn with Prolene in turn
- The artery is doubly ligated with suture
- The right bile duct(s) is (are) oversewn with Prolene
- A careful check of the raw surface is carried out, looking for hemostasis and the absence of new bile leaks
- A completion cholangiogram is performed to document the integrity of the remaining bile duct system and to check for leaks. The catheter is removed and the cystic duct is doubly ligated
- The abdominal cavity is copiously irrigated with antibiotic-laden solution
- One closed-suction drain is placed in the immediate vicinity of the resection towards the cut edge of the liver
- The position of the nasogastric tube is checked
- Perioperative antibiotics are given preoperatively, but are repeated as necessary, depending on time intraoperatively; thus if a first-generation cephalosporin is used, a redosing occurs at two hours following the initial dose
- Wound towels and the retractor are removed
- The abdominal wall is closed in layered fashion with attention to hemostasis
- The skin is closed in the usual fashion

**Post-op same day work through discharge from recovery**

- Apply dressings; Drainage from the drain is checked and their volume recorded; Abdominal girth is measured every six hours to make certain that bile and/or ascites is not accumulating; Check position and function of nasogastric tube; Write orders for post-op labs, films, medications, diet, and patient activity; Review recovery room care and medications with staff; Discuss procedure outcome with family; Discuss procedure outcome with patient after emergence from anesthesia; Dictate post-op report; Discuss procedure outcome with referring physician; Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company

**Post-op same day work after discharge from recovery**

- Examine patient, check wounds and patient progress; Review nursing/other staff patient chart notes; Answer patient family questions; Answer nursing/other staff questions; Write orders for following day's labs, films, medications, diet, and patient activity; Chart patient progress notes; Inform donor of recipient progress

**Post-op other hospital work – Beginning on post-op day 1, until discharge day**

- Check the drainage from right upper quadrant and record; Record abdominal girth; Continue antibiotics as indicated; Check liver chemistries every other day; Check urine output and measure urine sodium, potassium, and osmolality; Treat ascites and hypoalbumenemia as indicated; Remove nasogastric tube at appropriate time; Examine and talk with patient; Check wounds and patient progress; Discuss patient progress with referring physician (verbal and written); Review nursing/other staff patient chart notes; Answer patient/family questions; Answer nursing/other staff questions (verbal and written); Answer insurance staff questions; Write orders for post-op labs, films, medications, diet, and patient activity; Chart patient progress notes; Remove Foley catheter, check for voiding

**Discharge day work**

- Examine and talk with patient; Check wounds and patient progress; Review nursing/other staff patient chart notes; Review post-discharge wound care and activity limitations with patient; Answer patient/family questions; Answer insurance staff questions; Write orders for post-discharge labs, films, and medications; Chart patient discharge notes

**Post-op office work – After discharge from hospital**

- Examine and talk with patient; Check wounds and patient progress; Answer patient/family questions; Answer insurance staff questions; Discuss patient progress with referring physician (verbal and written); Write orders for medications; Review post-discharge labs/films (the patient's liver function is assessed to make sure that there is no evidence of hepatic insufficiency); Discuss progress with patient/family; Remove sutures/drains; Dictate patient progress notes for medical chart

**SURVEY DATA**

<b>Presenter(s):</b>	Michael Abecassis, MD, FACS; Charles Mabry, MD, FACS					
<b>Specialty(s):</b>	American Society of Transplant Surgeons; American College of Surgeons					
<b>CPT Code:</b>	471X3 (BB4)					
<b>Sample Size:</b>	130	<b>Resp n:</b>	36	<b>Resp %:</b>	28%	
<b>Sample Type:</b>	Random					
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		60.00	65.00	75.00	90.00	110.00
<b>Pre-Service Evaluation Time:</b>				105		
<b>Pre-Service Positioning Time:</b>				15		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				15		
<b>Intra-Service Time:</b>		380	420	480	600	630
<b>Post-Service</b>	<b>Total Min<sup>1</sup></b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	60					
<b>Critical Care time/visit(s):</b>	82	99233* x 2			LOS = 12	
<b>Other Hospital time/visit(s):</b>	237	99233 x 2; 99232 x 2; 99231 x 5				
<b>Discharge Day Mgmt:</b>	36	99238				
<b>Office time/visit(s):</b>	107	99213 x 4; 99212 x 1				

<sup>1</sup>Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
471X3	<i>Donor hepatectomy, with preparation and maintenance of allograft, from living donor; total right lobectomy (segments V, VI, VII and VIII)</i>	REC 75.00	90
47130	Hepatectomy, resection of liver; total right lobectomy	55.35	90
47135	Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age	81.51	90

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

	Svy CPT 471X3	Primary Ref 47130 RUC 2 <sup>nd</sup> 5yr	Svy CPT 471X3	Secondary Ref 47135 RUC Feb94
<b>TIME ESTIMATES (MEDIAN)</b>				
Pre-service	135	75	135	120
Intra-service	480	240	480	520
Same Day Immediate Post-service	60	45	60	700
Critical care	82	126	82	
Other hospital visit	237	210	237	
Discharge day management	36	36	36	
Office visit	107	61	107	161
<b>TOTAL TIME</b>	<b>1,137</b>	<b>793</b>	<b>1,137</b>	<b>1,501</b>
<b>INTENSITY/COMPLEXITY MEASURES (mean)</b>				
Survey response count	12	12	13	13
<b>TIME SEGMENTS</b>				
Pre-service	4.80	3.40	4.92	4.33
Intra-service	4.80	3.70	5.00	4.50
Post-service	4.60	3.30	4.50	4.33
<b>MENTAL EFFORT AND JUDGMENT</b>				
The number of possible diagnosis and/or the number of management options that must be considered	3.91	3.73	4.77	4.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.82	3.36	4.92	4.08
Urgency of medical decision making	4.27	3.45	4.69	4.08
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>				
Technical skill required	4.82	3.73	5.00	4.54
Physical effort required	4.73	3.64	5.00	4.46
<b>PSYCHOLOGICAL STRESS</b>				
The risk of significant complications, morbidity and/or mortality	4.90	3.70	5.00	4.23
Outcome depends on the skill and judgment of physician	4.90	3.80	5.00	4.15
Estimated risk of malpractice suit with poor outcome	4.80	3.10	4.77	3.85

**ADDITIONAL RATIONALE**

**The survey median RVW of 75.00 is being recommended for 471X3.** Compared with 47130, an RVW of 75.00 for 471X3 reflects: 1) increased intensity and complexity; 2) additional pre-operative time for team surgery and multiple patient coordination; and 3) additional intra-operative time/work for the donor procedure and for preparation and maintenance of the graft. Relative to 47135, the median RVW is below 81.51 which reflects slightly less intra-operative time and less post-operative time. The pre-, intra-, and post-op intensities for 471X3 and 47135 are very similar.

### **1. Discussion of time and complexity/intensity comparison**

Following is a detailed discussion of the similarities and differences between new code 471X3 and the primary reference code (47130) relative to the complexity/intensity values shown in the table above.

**Pre-service comparison:** Preoperative work for 471X3 differs markedly from that of a patient undergoing 47130. Not only must the potential donor be free of any medical or psychosocial contraindications to living donation (an essential condition required to minimize donor risk), but the status of the donor liver requires maximum attention. A preoperative knowledge and pre-operative review of the vascular and biliary anatomy is essential since often these anatomical variants will require additional efforts by the surgical team to produce a viable transplant organ.

**Intra-service technical comparison:** In contrast to 47130, the presence of large essential tributaries of the middle hepatic vein draining segments V and VIII (the anterior segments of the right lobe) require preservation for potential implantation when performing 471X3. 47130 requires the preservation of the sectoral and segmental arterial branches of the right hepatic artery, which are ligated and divided as they are encountered, whereas in 471X3, these must be carefully dissected and preserved in order to ensure viability of the right lobe graft. Likewise, in 47130, the right portal vein is typically ligated in continuity past the bifurcation with the left portal vein or alternatively divided in the parenchyma of the liver. Again, little attention is paid to preservation of the structure. In contrast, in 471X3, the right portal vein must be dissected and preserved. In cases of early branching of the right portal vein, the right anterior and right posterior portal veins must be individually dissected and preserved. The major difference in the dissection and mobilization of the portal vein between the two procedures is that in 47130, the right lobe structures are divided as they are encountered. This allows for easy visualization of the right portal vein. In contrast, in 471X3, the structures cannot be divided and, therefore, visualization of the portal vein requires careful mobilization of these anterior structures.

With 47130, it is not usually necessary to dissect the plane between the IVC and the caudate lobe. The parenchymal transection plane can be carried down to the right of the IVC in the vast majority of cases unless a trisegmentectomy is contemplated. In contrast, in 471X3, it is essential to divide the large number of caudate and accessory veins draining the caudate lobe and the right posterior lobe directly into the IVC. This dissection is essential because the right hepatic vein will need to be taken at its origin with the IVC and the surgeon must be able to place a finger directly beneath the caudate lobe so that the plane of parenchymal transection will be in line with the eventual division of the right portal vein(s). In addition, this may require division of caudate branches from the right portal vein to the caudate lobe which requires dissection not needed in a right hepatic lobectomy. The presence of accessory right hepatic veins, also known as "short veins," makes this dissection more difficult, since the right lobe cannot be reflected from the IVC with these veins tethering it down.

With 47130, the blood supply to the right lobe is taken early (hilar control), before parenchymal transection, so that a line of demarcation between the ischemic right lobe and the remaining viable liver guides the surgeon as to the plane of transection. One advantage of this is that typically surgeons will err slightly on the ischemic side and the parenchymal transection will be relatively bloodless given the lack of blood supply (with the exception of comeback vessels and some hepatic venous bleeding). In contrast, vascular inflow cannot be controlled in 471X3 in light of the need for a viable graft. Therefore, the parenchymal transection is performed without any type of inflow control. This results in a potentially bloody parenchymal transection and, given the important need for donor safety (including the need to avoid blood transfusion and hemodynamic instability), this requires a parenchymal transection. In order to avoid exsanguinating hemorrhage, this technique of parenchymal transection is much slower. In addition, the hepatic vein anomalies may require preservation of veins draining segments V and VIII for a possible reconstruction. Dissection of these veins within the hepatic parenchyma slow down the process of parenchymal transection.

**Graft comparison:** In contrast to a liver specimen in 47130, attention must be paid to the raw surface of the right lobe graft for bleeding points and biliary leaks in 471X3. This not only requires suture ligation of all vascular and biliary structures during the parenchymal transection, but a very careful examination of the raw surface of both sides once this parenchymal transection is completed. Biliary complications are the Achilles' heel of living donor transplants. Therefore, attention must be paid to the preservation of a vascularized biliary tree. In 47130, the vascular supply to the biliary tree is not of concern. In 471X3, dissection is necessary to preserve the blood supply of the biliary system. This dissection is time consuming and is typically performed with high magnification loupes. Also, since the remaining stump on the donor's bile duct is typically short, careful oversewing of this stump is essential in ensuring donor safety and preventing biliary leakage in the donor. This is in contrast to ligation and division of whatever biliary structures are encountered during 47130.

**Technical skill comparison:** The performance of living donor liver transplantation requires significant knowledge and training. When performed in children, the procedure is typically performed either by a pediatric surgeon who has received additional training in transplant surgery or by a transplant surgeon who has received additional training in pediatric surgery. Both groups undergo training in ASTS-accredited programs. When performed in adults, this procedure is performed by a transplant surgeon who likewise has undergone training in an ASTS-accredited program. The ASTS accreditation standards for transplant surgery fellowship programs require that each fellow must perform at least 45 liver transplants over the course of his or her fellowship.

**Stress comparison:** The level of stress involved in operating on an otherwise healthy individual compounds the usual level of stress associated with major surgical procedures. Although the recipients derive direct benefit from the transplant, it is difficult to assign any physical benefit to the donor. This fact adds tremendously to the process of informed consent for 471X3 and makes a benefit-to-risk analysis impossible from the donor's perspective. These concepts must be continuously communicated to the donor and his or her family and to those clinical professionals involved in the provision of healthcare to the donor.

## 2. IWPUT Analysis

The following IWPUT analysis using the Building Block Methodology is provided to show that the IWPUT for new code 471X3 is reasonably similar to 47130. [It is also similar to 471X1, which has an IWPUT of 0.113 based on the recommended RVW of 55.00 and to 471X2, which has an IWPUT of 0.118 based on the recommended RVW of 67.50.] This analysis is another way to compare procedures in the same family with different time and visit patterns for pre- and post-service work. This analysis also allows for differences in intraoperative time. It is another way to show that the median survey RVW of 75.00 for 471X3 is reasonable when compared with 47130, 471X1, and 471X2. Note: An IWPUT comparison with 47135 cannot be performed. This code was surveyed in 1993, using a previous version of the RUC survey that did not include details for postoperative visits.

		IWPUT ANALYSIS					
ROW / COLUMN	A	B	C	D	E	F	
1	<b>471X3 and</b>	<b>471X3</b>	<b>Svy RVW:</b>	<b>75.00</b>	<b>47130</b>	<b>MFS RVW:</b>	<b>55.35</b>
2	<b>47130</b>	<b>Svy Data</b>	<b>RUC Std.</b>	<b>RVW</b>	<b>Svy Data</b>	<b>RUC Std.</b>	<b>RVW</b>
3	<b>Pre-service:</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>
4	Pre: eval & posit	120	0.0224	2.69	50	0.0224	1.12
5	Pre: scrub,dress,wait	15	0.0081	0.12	25	0.0081	0.20
6	<b>Pre-service total</b>			<b>2.81</b>			<b>1.32</b>
7	<b>Post-service:</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>
8	Immediate post	60	0.0224	1.34	45	0.0224	1.01
9	<b>Subsequent visits:</b>	<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>	<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>
10	ICU 99291		4.00		2	4.00	8.00
11	99233	4	1.51	6.04	2	1.51	3.02
12	99232	2	1.06	2.12	3	1.06	3.18
13	99231	5	0.64	3.20	2	0.64	1.28
14	Discharge 99238	1	1.28	1.28	1	1.28	1.28
15	Discharge 99239		1.75			1.75	
16	99215		1.73			1.73	
17	99214		1.08			1.08	
18	99213	4	0.65	2.60	2	0.65	1.30
19	99212	1	0.43	0.43	1	0.43	0.43
20	<b>Post-service total</b>			<b>17.01</b>			<b>19.5</b>
21	<b>Intra-service:</b>	<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>	<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>
22	<b>Intra total</b>	<b>480</b>	<b>0.115</b>	<b>55.18</b>	<b>240</b>	<b>0.144</b>	<b>34.53</b>

**3. Additional NOTE about work prior to the day before surgery**

As noted in the cover letter accompanying this Summary Form, multiple potential donors are evaluated prior to selecting a donor for a liver transplantation. The services provided to potential donors include information sessions and face-to-face explanations of risks and benefits. The level of work that goes into the identification of a suitable donor is quite extensive and is not compensated, since no service is rendered to the individuals who do not donate. The time and work associated with these services is NOT included in the recommended RVW for 471X2.

---

**Services Reported with Multiple CPT Codes**

To be provided under separate cover.

---

**FREQUENCY INFORMATION****How was this service previously reported?**

47399 Unlisted procedure, liver

The following two codes *may* also have been used, but are *not accurate* for this new procedure:

47134 Donor hepatectomy, with preparation and maintenance of allograft; partial, from living donor

47130 Hepatectomy, resection of liver; total right lobectomy.

**How often do physicians in your specialty perform this service?**

Specialty: transplant surgery                      Commonly      Sometimes      Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period?**

Specialty: transplant surgery

Frequency: The precise utilization of this procedure is not known. The first series of adult-to-adult living donor liver transplants in the United States was presented in 1998. Data from the United Network for Organ Sharing (UNOS) indicate that there were 25 adult-to-adult LDLTs in 1998, 133 in 1999, and 250 in 2000. While UNOS data does not separately report right and left lobe procedures, ASTS believes that the vast majority of these procedures involved right lobe transplants. UNOS data on the number of adult-to-adult transplants for 2001 is not yet available.

**For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?**

Specialty: transplant surgery                      Frequency: unable to estimate

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

---

## **Description of the four preoperative phases prepared by ASTS**

### **Preoperative evaluation of potential living donor:**

#### **Phase 1:**

The patient in need of liver transplantation has been told to bring any “potential donors” and their families to an information session regarding living donor liver transplantation. The surgeon or physician introduces the session. At that point, a nurse that is part of the “donor advocate team” as outlined in the NY State Guidelines provides a full overview of the medical, surgical, financial, ethical and logistical issues involved in the process of living donation. The risks to the donor are explained in detail, as are the technical and logistical details of both the donor and recipient procedures. In addition, the risks and potential benefits to the recipient are discussed, including the added risks of living donor transplantation as compared to cadaver donor transplantation. All known complications to both donors and recipients are discussed in terms of published data, rumored data, and center-specific data. A plan is outlined regarding “next steps” that include blood typing of any potential donors (must be compatible), filling out of a health questionnaire by all potential donors, and the ranking process by the center if more than one potential donor exists. Finally, the confidential nature of the process is stressed, emphasizing that from this moment on, no details about any interaction between the potential donor and the transplant center will be shared with anyone other than the potential donor.

#### **Phase 2:**

Potential donors with compatible blood type are ranked and contacted by the nurse (donor advocate team) in order, one at a time. The potential donor is told that both their blood type and medical questionnaire reveal no contraindications to proceeding with a “work up”. The donor is told to contact the designated nurse, once they have discussed this development with their immediate family if they wish to proceed. The potential donor is told in no uncertain terms that a “medical excuse” will be provided in case they do not wish to proceed, and that the recipient, or anyone else for that matter will not be told anything other than there were medical reasons not to proceed. If the potential donor contacts the nurse and wishes to proceed, consent is obtained from the potential donor to proceed with a “work up”. An appointment is made with a “donor advocate team” physician for a complete history and physical examination to rule out potential medical contraindications to donation. If no contraindications are discovered during the history and physical examination, blood work is ordered consisting of standard hematology and chemistries, including liver function tests and serologies for various viral infections. A psychosocial evaluation is included to rule out psychosocial contraindications to donation. An effort is made to rule out coercion and any possibility of financial gain by the potential donor. If the blood work reveals no contraindications, the potential donor is contacted by the nurse and informed of the results. Again, at this point, the nurse informs the potential donor of the possibility of a “medical excuse”. The potential donor is instructed to contact the nurse after a discussion with his immediate family regarding the results of the testing if he wishes to proceed. If the potential donor contacts the nurse, an appointment is made for further investigations now directed specifically at the liver. These may include imaging (CT or MR depending on the preference of the center), liver

biopsy if indicated, and angiography if indicated. Of course, the appropriate consent is obtained prior to each procedure, particularly for invasive procedures.

If the potential donor opts out of the process at any point, a “medical excuse” is provided, and the nurse contacts the next ranked potential donor, and phase 2 is initiated for the new potential donor. If no other donor is identified, the recipient is informed that living donor transplantation will not be possible, and they are encouraged to broaden their search for a potential donor.

If the potential donor accepts to proceed to the next step, the transplant surgeon becomes involved by reviewing all medical and psychosocial information and making a determination that indeed this is an appropriate donor. Also, the potential donor is offered the opportunity to call other donors who have volunteered to discuss their experiences with potential donors. The nurse arranges these calls.

#### Phase 3:

The potential donor and their immediate family are invited to a discussion with the transplant team regarding the procedure and its inherent risks. The surgeon spends a considerable amount of time discussing complications, alternatives, uncertainties and technical aspects of the surgery. The nurse presents information regarding the personal, financial and psychological implications of the procedure. Once again, the donor and their immediate family are offered a “medical excuse”. Also, they are told that if a single member of the immediate family is not fully engaged and agreeable with proceeding, the procedure will not take place. The surgeon and the nurse together establish that there are no immediate family members or significant others who may not be present during this session. If this is found to be the case, every effort is made to engage these individuals. At the end of this session, consent is obtained for the donor procedure from the donor and their immediate family.

At this point, the recipient and his immediate family is invited to join the discussion. The surgeon and the nurse point out the details of the recipient procedure, its inherent risks, how the living donor transplant procedure differs from a cadaver donor procedure, and the added risks to the recipient with living donor transplants. Every effort is made to achieve consensus amongst the members of both families that the process should continue.

The procedure is scheduled and a return appointment is made for the donor and his immediate family in 30 days, coinciding with 24 hours prior to the procedure. This is a “cooling” off period recommended by the NY State guidelines.

#### **Consent process for surgery:**

#### Phase 4:

The donor and his immediate family is interviewed for the purposes of informed choice. They have presumably had an opportunity to discuss all issues related to the procedure and have elected to proceed. At this time, both the surgeon and the nurse spend a

considerable amount of time reviewing all the technical details of the surgery including a thorough explanation of the preoperative details, including the option of epidural anesthesia, the need for invasive monitoring catheters, the incision, the details of the liver anatomy necessary to understand the risks (pictures are used to review the anatomy of the liver), the volume of liver that will be removed, the anatomy of the vascular and biliary structures, the need for drains, the postoperative details leading to discharge from the hospital, the restrictions involved, the follow up regimen, and any potential complications, both short term and long term.

After the nurse has fully “informed” the patient and his immediate family, the surgeon attempts to talk the donor out of donating. He emphasizes the serious complications, including death, liver failure in the donor and the need for transplantation, biliary leaks and strictures that may require re-operation, bleeding and infections.

At the end of the session, the donor and his immediate family are asked to sign an “informed choice” form indicating that the process has taken place. The nurse then goes over the details of the admission to hospital the following day, when they must be at the hospital, where to go, what to expect upon arrival, when they need to be NPO, what to bring or not to bring to the hospital etc. She answers whatever questions the donor and his family may still have that have not been answered.

#### Phase 5:

On the day of surgery, the patient signs the standard hospital informed consent. The actual signing of this consent may take place in the surgeons office on the day prior to surgery. However, on the day of surgery, the surgeon spends the necessary time to make sure that the donor understands all pertinent issues relating to the surgery, and that he understands that he can still back out of this with a “medical excuse”. If the donor wishes to proceed, he is taken to the operating room.

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
090 Day Global Period  
Facility Direct Inputs**

CPT	DESCRIPTION	GLOBAL
47140	Donor hepatectomy, with preparation and maintenance of allograft, from living donor; left lateral segment only (segments II and III)	90
47141	Donor hepatectomy, with preparation and maintenance of allograft, from living donor; total left lobectomy (segments II, III and IV)	90
47142	Donor hepatectomy, with preparation and maintenance of allograft, from living donor; total right lobectomy (segments V, VI, VII and VIII)	90

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:** The direct practice expense details were developed by physicians from the American Society of Transplant Surgeons.

**CLINICAL STAFF TYPE:**

Because of the complex nature of procedures that are performed by transplant surgeons, a registered nurse in the minimum clinical staff level hired. We are requesting that the staff type for these service be identified as RN (CMS code 1033).

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time (prior to admission):** For each of these 90-day facility only procedures, the standard "typical" 60 minutes have been applied. Additional minutes are being recommended for coordination of care, pre-service education, and pre-service diagnostic and referral forms. A discussion of the necessary preservice work is discussed in the cover letter to our recommendations. We submit that presentation as a rationale/justification for requesting the following additional minutes of clinical staff time:

Other Clinical Activity: 15 minutes for significant additional atypical coordination because of multiple physicians, surgeons, and two patients.

Other Clinical Activity: ~~480 minutes for significant additional atypical pre-service education. Four information sessions with donor and family at approximately 2 hours each.~~

Other Clinical Activity: 30 minutes for significant additional "atypical" pre-service diagnostic & referral forms.

**Service period clinical staff time (admission to discharge):**

Pre-service: N/A

Intra-service: N/A

Post-service: 12 minutes of clinical staff time for work related to facility discharge (99238 level).

**Post-service period clinical staff time:** Standard EM postop visit time for clinical staff has been applied for each office visit.

**SUPPLIES AND EQUIPMENT:**

Supplies and equipment necessary at each post-op visit are presented.

---

AMA/Specialty Society RVS Update Commit		47140		47141		47142	
471X1-471X3 PE Details (April 2003 RUC)		Donor hepatectomy, with preparation and maintenance of allograft, from living donor; left lateral segment only (segments II and III)		Donor hepatectomy, with preparation and maintenance of allograft, from living donor; total left lobectomy (segments II, III and IV)		Donor hepatectomy, with preparation and maintenance of allograft, from living donor; total right lobectomy (segments V, VI, VII and VIII)	
CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE		90		90		90	
GLOBAL PERIOD		90		90		90	
LOCATION		NonFac	Fac	NonFac	Fac	NonFac	Fac
TOTAL CLINICAL LABOR TIME	1033 RN	N/A	458	N/A	494	N/A	494
PRE-SERVICE PERIOD TOTAL TIME	1033 RN		285		285		285
SERVICE PERIOD TOTAL TIME	1033 RN		12		12		12
POST-SERVICE PERIOD TIME	1033 RN		161		197		197
<b>PRE-SERVICE PERIOD</b>							
Complete pre-service diagnostic & referral forms	1033 RN		5		5		5
Coordinate pre-surgery services	1033 RN		20		20		20
Schedule space and equipment in facility	1033 RN		8		8		8
Provide pre-service education/obtain consent	1033 RN		20		20		20
Follow-up phone calls & prescriptions	1033 RN		7		7		7
<u>Other Clinical Activity:</u> Significant additional "atypical" coordination because of multiple-physicians, surgeons, and two patients	1033 RN		15		15		15
<u>Other Clinical Activity:</u> Significant additional atypical pre-service education Four information sessions with donor and family at approximately 2 hours each.	1033 RN		180		180		180
<u>Other Clinical Activity:</u> Significant additional "atypical" pre-service diagnostic & referral forms.	1033 RN		30		30		30
<b>SERVICE PERIOD</b>							
Pre-service			0		0		0
Intra-service			0		0		0
Post-Service							
Discharge day management 99238 --12 minutes 99239 --15 minutes	1033 RN		12		12		12
Other Clinical Activity (please specify)							
<b>POST-SERVICE PERIOD</b>							
Conduct phone calls/call in prescriptions							
<i>List Number and Level of Office Visits</i>							
99211 16 minutes							
99212 27 minutes							
99213 36 minutes			3		4		4
99214 53 minutes			1		1		1
99215 63 minutes							
<b>Total Office Visit Time</b>	1033 RN		161		197		197
Other Activity (please specify)							
<b>MEDICAL SUPPLIES</b>							
minimum visit package (multispecialty)	PEAC pack		3		5		5
post-op incision care kit	PEAC kit		1		1		1
<b>Equipment</b>							
exam table	E11001		1		1		1
exam lamp	E30006		1		1		1

**NEW YORK STATE  
COMMITTEE ON  
QUALITY IMPROVEMENT  
IN LIVING LIVER DONATION**

**A Report to:**

**New York State Transplant Council**

**and**

**New York State  
Department of Health**

**October 2002**

**DRAFT**

State of New York  
George E. Pataki, Governor  
Department of Health  
Antonia C. Novello, M.D., M.P.H., Dr. P.H., Commissioner

**TABLE OF CONTENTS**

	<u>PAGE</u>
1	
2	
3 <b>New York State Committee on Quality</b>	
4 <b>Improvement in Living Liver Donation</b>	<b>3</b>
5	
6 <b>New York State Department of Health Staff</b>	<b>6</b>
7	
8 <b>I. INTRODUCTION</b>	<b>7</b>
9	
10 <b>II BACKGROUND</b>	<b>8</b>
11 <b>A. The Donor</b>	<b>8</b>
12 <b>B. The Recipient</b>	<b>9</b>
13 <b>C. The Family</b>	<b>10</b>
14 <b>D. Transplant Center</b>	<b>10</b>
15	
16 <b>III. INDEPENDENT DONOR ADVOCATE TEAM</b>	<b>12</b>
17 <b>A. Team Characteristics</b>	<b>12</b>
18 <b>B. Team Responsibilities</b>	<b>13</b>
19 <b>C. Education</b>	<b>13</b>
20	
21 <b>IV. INFORMED CHOICE</b>	<b>15</b>
22 <b>A. Informed Understanding</b>	<b>15</b>
23 <b>B. Disclosure</b>	<b>16</b>
24 <b>C. Risks</b>	<b>17</b>
25 <b>D. Choice</b>	<b>18</b>
26 <b>E. Documentation</b>	<b>18</b>
27 <b>F. Decision to Donate</b>	<b>18</b>
28	
29 <b>V. EVALUATION</b>	<b>19</b>
30 <b>A. Primary Medical Evaluation</b>	<b>19</b>
31 <b>B. Psychiatric and Social Requirements</b>	<b>19</b>
32	
33 <b>VI. LIVER TRANSPLANT RECIPIENTS</b>	<b>21</b>
34	
35 <b>VII. PERIOPERATIVE CARE AND FACILITY SUPPORT</b>	<b>22</b>
36 <b>A. Preoperative Preparation</b>	<b>22</b>
37 <b>B. Operative Teams</b>	<b>22</b>
38 <b>C. Qualifications of Surgical Team</b>	<b>22</b>
39 <b>D. Postoperative Care</b>	<b>24</b>
40 <b>E. Medical Staffing</b>	<b>25</b>
41 <b>F. Nursing Staffing</b>	<b>25</b>
42 <b>G. Radiology</b>	<b>26</b>
43	
44 <b>VIII. DISCHARGE PLANNING</b>	<b>27</b>
45 <b>A. Predonation</b>	<b>27</b>
46 <b>B. Discharge Plan</b>	<b>27</b>
47 <b>C. Postdischarge</b>	<b>28</b>
48 <b>Appendix 1 NYCLT online Data Collection Instrument</b>	<b>30</b>
49 <b>Appendix 2 Survey</b>	<b>35</b>

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48

# New York State Committee on Quality Improvement in Living Liver Donation

**Chairperson**

**David Conti, M.D.**

Professor of Surgery

Albany Medical Center

Albany, NY

**Francis L. Delmonico, M.D.**

Professor of Surgery, Harvard Medical School

Director, Renal Transplant Program

Massachusetts General Hospital

Boston, MA

**Nancy Dubler, J.D, L.L.B**

Director, Division of Bioethics

Albert Einstein College of Medicine

Professor of Bioethics

Department of Epidemiology & Social Medicine

Montefiore Medical Center

New York, NY

**Nancy Fraser, M.S.W., C.S.W, A.C.S.W.**

Social Worker, Renal Transplant Program

Albany Medical Center

Albany, NY

**Elizabeth A. Pomfret, M.D., Ph.D.**

Assistant Professor of Surgery,

Tufts University, School of Medicine

Director, Living Liver Transplant Program

Lahey Clinic

Burlington, MA

**John R. Lake, M.D.**

Professor of Medicine and Surgery

Director, Gastroenterology Division

Director of Liver Transplantation Program

University of Minnesota

Minneapolis, MN

**Marlene Marciniak**

Liver Donor

North Tonawanda, NY

**J. Michael Millis, M.D.**

**DRAFT –October 18, 2002**

1 Associate Professor of Surgery  
2 Chief, Section of Transplantation Surgery  
3 Director, Liver Transplantation and Hepatobiliary Surgery  
4 University of Chicago  
5 Chicago, IL

6  
7 **Ronnie Schwartz**  
8 Liver Transplant Recipient  
9 New York, NY

10  
11 **Mark Simon**  
12 Executive Director  
13 Upstate New York Transplant Services  
14 Buffalo, NY

15  
16 **Owen Surman, M.D.**  
17 Associate Professor of Psychiatry, Harvard Medical School  
18 Psychiatric Consultant to the Transplant Service  
19 Massachusetts General Hospital  
20 Boston, MA

21  
22 **Michele White, R.N.**  
23 New York State Nurses Association  
24 Columbia Presbyterian Medical Center  
25 New York, NY

26  
27  
28 **Representatives of New York State Facilities with Living Liver**  
29 **Transplant Programs**

30  
31 **Adel Bozorgzadeh, M.D.**  
32 Director, Solid Organ Transplantation  
33 University of Rochester Medical Center  
34 Rochester, NY

35  
36 **Jean Emond, M.D.**  
37 Thomas S. Zimmer Professor of Surgery  
38 Vice Chairman and Chief of Transplantation Services  
39 New York Presbyterian Hospital Columbia University  
40 New York, NY

41  
42 **Leona Kim-Schluger, M.D.**  
43 Chief, Adult Liver Transplantation Medicine  
44 Recanati/Miller Transplant Institute  
45 Mount Sinai Medical Center  
46 New York, NY

47  
48 **Patricia Ann Sheiner, M.D.**  
49 Director, Liver Transplantation and Hepatobiliary Surgery

**DRAFT –October 18, 2002**

1 Westchester Medical Center  
2 Valhalla, NY  
3  
4 **Lewis Teperman, M.D.**  
5 Director, Liver Transplant Program  
6 New York University Medical Center  
7 New York, NY

**New York State Department of Health Staff**

**Wayne M. Osten**

Director

Office of Health Systems Management

**Lisa M. Wickens, R.N.**

Assistant Director

Office of Health Systems Management

**Lisa McMurdo, R.N., M.P.H.**

Project Director

Division of Health Care Standards and Surveillance

**Marjory Scarlet Simmons**

Acting Director

Bureau of Standards Development

**Kimberly Valente, R.N.**

Health Policy Associate

Bureau of Standards Development

**Anne M. Anzola**

Health Program Administrator III

Bureau of Standards Development

**Judith Doesschate, Esq.**

Division of Legal Affairs

**Nancy Nusca, R.N.**

Management Fellow

**Charles Bonsu**

Management Fellow

**Frederick Heigel**

Bureau of Hospital Services

**Lisa Thomson, Secretary**

Bureau of Standards Development

**Patricia A. Lewis, Secretary**

Bureau of Standards Development

**I. INTRODUCTION**

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29

Commissioner of Health Antonia C. Novello, M.D., M.P.H., Dr. P.H., created the New York State Committee on Quality Improvement in Living Liver Donation in June 2002 to review living-related liver donation in New York State. The Committee operates under the auspices of the New York State Transplant Council, New York’s 21-member advisory body appointed by the Governor and the State Legislature to advise the Commissioner of Health on issues related to organ and tissue donation and transplant.

The Committee met in June, August, October, and November 2002 to review existing requirements and protocols and develop guidelines and protocols concerning donor and recipient selection, informed consent, preoperative evaluation, intraoperative and postoperative care of living liver donors.

Members of the Committee include transplant physicians, an organ procurement organization representative, transplant recipient and donor, a nurse, social worker, and psychiatrist with transplant experience, an ethicist and representatives from the five liver transplant programs in New York State.

Three subcommittees were formed at the first meeting of the Committee: Subcommittee on Informed Consent, Donor/Recipient Selection and Evaluation (Francis L. Delmonico, M.D., chair), Subcommittee on Donor Peri-Operative Care and Facility Support (Lewis Teperman, M.D., chair) and Subcommittee on Donor Discharge Planning, Support and Long-Term Follow-up (Jean Emond, M.D., chair). Commissioner Novello asked the Committee members to formulate recommendations and draft guidelines before the end of the year.

This report represents the diligent work of the Committee and contains guidelines to help reduce morbidity and mortality associated with live adult liver donation in New York State.

## II. BACKGROUND

The availability and quality of an organ obtained from a live donor and the continuing shortage of organs recoverable from deceased donors has propelled an extensive effort in live organ transplantation that places more live organ donors at medical risk. The wellbeing of the donor should be the primary consideration of any live donor organ transplantation. Although the possibility of injury to a live donor has been acknowledged since the inception of organ transplantation as a viable medical field, a basic tenet of medicine is to do no harm. The transplantation of an organ from a live donor stands in ethical contrast to every other care that a physician provides. If a seriously ill patient does not completely understand a plan of treatment, the physician may still act in his or her best interest. However, if a living donor does not understand the process and risks of donation, the consequences of their not assimilating the important information are profound.

Competing interests arise in live organ donation that are unique. These include the interests of the donor, the needs of the recipient as well as society for tissues or organs for transplantation, the interests of the next of kin of both the donor and recipient, and the interests of the transplant center.

### A. The Donor

Some potential donors donate selflessly for the good of either a family member, loved one, or society. The potential donor must understand the following points:

1. In contrast to the consent for donation at the time of death, the living donor is confronted with either immediate risk or unknown future medical problems related to his or her organ system. These risks may not be entirely known at the time a living donor procedure is undertaken (such as a right lobe liver transplantation or laparoscopic nephrectomy).
2. The financial and emotional consequences of the donation must be understood. At a minimum, the donation process can cause stress in the family and limit the functionality of the donor for weeks or months following the operation. A quantifiable financial impact of this

**DRAFT –October 18, 2002**

- 1 3. loss of functionality must be addressed before the transplant is performed. Complications of  
2 the donation procedure may have limited consequences or may evolve into a state of chronic  
3 illness and lead to loss of employment and loss of medical insurability. The donor’s family  
4 must consider the possibility of such an outcome, even though it may be unlikely.  
5
- 6 4. Emotional consequences that are much harder to quantify may have a variable impact upon  
7 certain members of the donor family and be dependent upon the ultimate decision to donate or  
8 not. For example, the decision to donate could have a positive emotional bearing upon  
9 siblings when a parent is in need of a transplant, while at the same time, having a negative  
10 effect on the donor’s primary family (spouse, children).  
11  
12

**B. The Recipient**

14 In most situations, the recipient would seem to have every reason to encourage living  
15 donation. The wait for a life-saving or life-enhancing organ is shortened, the transition to a more  
16 functional life is accelerated, and the emotional strain of “the wait” for a deceased donor’s organ  
17 is eliminated. However, some potential recipients do not opt to pursue the living donor option for  
18 a variety of reasons. The recipient may acknowledge that a social behavior is the source of organ  
19 failure and illness and may not want to ask a family member to undertake risk in this clinical  
20 setting. The recipient should understand:  
21

- 22 1. Transplantation, whether via a deceased donor or living donor source, is not a process that can  
23 be successfully accomplished alone. The recipient must understand that his or her outcome  
24 will be dependent on someone’s desire to help and to provide a gift individually or to society.  
25 In addition, the family is critically important to the success of the endeavor. Even a transplant  
26 from a deceased donor will require the sacrifice of time, effort, emotion, and functionality of  
27 at least one if not more family members.  
28
- 29 2. The recipient should understand that there are risks for a live donor, but that the selection  
30 process and the medical, surgical, and associated health care providers attempt to minimize  
31 these risks and ensure that the donor is proceeding voluntarily and safely with the decision to  
32 donate.

1 3. The recipient should understand that there may be additional risks associated with receiving a  
2 living donor graft versus a graft from a deceased donor. These negative factors may be  
3 countered by fewer complications in the pretransplant period.

4  
5 4. The recipient should understand that he or she should be placed on the transplant waiting list  
6 and that the team will pursue a deceased donor source of organs so that the recipient does not  
7 feel the need to apply pressure on the potential donor and create a coercive environment. The  
8 recipient must not feel that living donation is the only option to successful transplantation.

9  
10  
11 **C. The Family**

12 The family of either the donor or recipient can be either supportive or coercive in the  
13 decision-making process. The family members have a stake in the decision, as they will be  
14 affected regardless of whether the decision is to donate or not. The decision not to donate could  
15 impact another family member’s fate while the decision to donate could directly impact the donor  
16 or his or her immediate family.

17  
18 The family should understand that living donation may not be the only option. This concept  
19 will assist in engendering a noncoercive environment for the potential donor to make an  
20 independent decision. Both the potential donor’s and recipient’s family should make their desires  
21 known to the potential donor in a noncoercive fashion.

22  
23  
24 **D. Transplant Center**

25 The professional staff of the liver transplant center is committed to helping patients with  
26 liver disease. However, as the demand for organs continues to increase and the pool of organs  
27 recovered from deceased donors remains insufficient, there is a compelling incentive for the  
28 transplant center to identify a living donor source of organs. The forces influencing the transplant  
29 center to solicit live donors include economic concerns, prestige/professional satisfaction, and the  
30 paramount desire to help the patients who entrust their future to transplant professionals.

31  
32 1. The recipient is the liver transplant program’s first and foremost concern. With the acceptance  
33 of care for the potential recipient, the entire liver transplant service becomes ethically bound

**DRAFT –October 18, 2002**

1 to consider either a deceased or living organ source to save the recipient’s life. However, only  
2 when a potential donor is determined to be suitable and becomes a possible surgical candidate  
3 does the surgical component of the transplant team have an additional ethical/professional  
4 relationship with the potential donor.

5  
6 2. Liver transplantation is a highly visible program of a medical center that conveys  
7 sophistication and technical expertise associated with an excellent institution. This uniqueness  
8 of medical care is the realm of living donor liver transplantation for the transplant physician.  
9 It fosters professional recognition, scientific publications, academic reward, and personal  
10 satisfaction.

11  
12 3. Liver transplantation generates significant revenue for a medical center. The need to maintain  
13 the skills of clinical service may propel the leaders of the program to consider living donation  
14 as an alternative source of the transplant.

### III. INDEPENDENT DONOR ADVOCATE TEAM

An independent donor advocate team should be established for any live donor adult liver transplantation program. The team’s interests must be exclusively the wellbeing of the live donor, to help donors make informed decisions, while balancing external/family pressures to donate. The team may not be totally independent of the recipient events, as there must be interaction with the transplant surgeon of the recipient team.

#### A. Team Characteristics

1. The independent advocate team should have no financial or personal interest in the decision to donate or transplant. The salary or compensation of the donor advocate team should not be dependent upon whether a particular live donor transplant is performed or how many transplants are performed by the center.
2. The independent advocate team’s status at the center should not be affected by decisions made on behalf of the donor.
3. The independent advocate team must be medically sophisticated in transplantation and aware of center volume, outcome data, and other relevant statistics.
4. The independent advocate team should consist of, at a minimum, a physician, a transplant coordinator, and a psychiatrist, psychologist or social worker. The Committee recommends the following:
  - a) All team members should have a solid working knowledge of liver disease and transplantation.
  - b) The psychiatrist, psychologist, or social worker (who should have a master’s degree or higher) should be skilled in individual and family counseling should understand the entire donation process, and have knowledge of and be able to provide information on community programs for social support including temporary housing and transportation to the surgical center.

**DRAFT –October 18, 2002**

- 5. Once an individual is designated by the center to serve as a member of the independent donor advocate team, they should:
  - a. Attend a continuing education course on living donation yearly;
  - b. Participate in at least one donor evaluation process per year.

**B. Team Responsibilities**

The independent donor advocate team’s role begins with the donor evaluation process and continues through donation, the postoperative period, discharge and post-discharge. The team should provide appropriate recognition, report adequacy of pain control, and facilitate additional postoperative contact with the appropriate hospital staff. Team members should ensure that all the needs of the donor are fulfilled in a prompt manner and in accordance with best medical practice. An attempt should be made to make donors feel special and to recognize the importance of their donation.

The team should:

- 1. structure the process of informed choice (specifically stating informed “choice”) and emphasize that the decision to donate is not a foregone conclusion;
- 2. protect the interests and wellbeing of the donor;
- 3. provide information regarding the medical, psychosocial, and financial implications of the live donation for the potential donor;
- 4. explain the evaluation process, what to expect and what it means to be a donor.
- 5. discuss with the donor the formal conclusion regarding his or her medical and psychosocial suitability for the surgery;
- 6. assure there is continuity of care.

**C. Education**

**DRAFT –October 18, 2002**

1 The independent donor advocate team should be instrumental in educating the potential donor  
2 about the donation process. The team should begin with facts known about the donation process,  
3 move through a discussion of these facts, and then end with helping the patient to reference his or  
4 her personal values to the facts known about donation. This should be a long and complex  
5 discussion, recognizing that only certain persons should be permitted to donate.

6  
7 The team should:

- 8 1. Evaluate the intellectual and emotional capacity of the prospective donor to exercise  
9 legally and ethically adequate informed choice. This process is far more complex than the  
10 evaluation of the decisional capacity of a patient to provide informed consent to a  
11 treatment that is offered in his or her best interest.  
12
- 13 2. Devise an individually appropriate process for informing the potential donor about the  
14 risks of the medical interventions, which makes clear that the benefits are speculative and  
15 the risks are serious and measurable.  
16
- 17 3. Balance the hopes of donors, recipients’ gratitude, and expectations of the potential  
18 donor’s sense of wellbeing from the altruistic behavior of donation against the real  
19 medical risks.  
20
- 21 4. Assure understanding of the elements of the decision. When the risks are great, the team  
22 should interact with the potential donor to be certain that all of the intellectual and  
23 emotional avenues have been traversed and that the patient has understood the risks and  
24 benefits and applied them to his or her personal situation and core values.  
25
- 26 5. Determine that the potential donor’s decision is voluntary. The donor should feel free to  
27 choose each option. Others should not try to influence the donor toward a particular  
28 decision.

## IV. INFORMED CHOICE

The forces that influence a donor are numerous and complex. The donor must be free to make an informed independent choice. The informed choice process is that part of the donation decision that helps to focus on the technical elements of the donation, surgery, recovery, and on the unknown and unforeseeable consequences that might in the short- or long-run change the patient’s life, health, employment, or emotional situation. The person who gives consent to be a live organ donor should be:

- competent;
- willing to donate;
- free from coercion;
- medically and psychosocially suitable;
- fully informed of the risks and benefits as a donor;
- fully informed of the risks, benefits, and alternative treatment available to the recipient; and
- likely to benefit in a specific, non-monetary way.

The benefits to both the donor and the recipient must outweigh the risks associated with the donation and transplantation of the living donor organ.

### A. Informed Understanding

1. Written and verbal presentations should be in lay language and in accordance with the person’s educational level.
2. The donor should be able to demonstrate that he or she understands the essential elements of the donation process, especially the risks associated with the procedure.
3. Adequate time should be allowed for the potential donor to absorb the information provided, ask questions, and have questions answered. This may require several consultations for the donor to absorb the information and formulate questions.

**DRAFT –October 18, 2002**

1 4. Written material provided to the potential donor should not only serve as a basis for consent  
2 but also as future reference for the donor.

3  
4 5. The donor’s family/loved ones should be given the opportunity to discuss their concerns.  
5  
6

7 **B. Disclosure**

8 1. The transplant team and the donor advocacy team should disclose their institutional  
9 affiliations to the potential donors.

10  
11 2. The relationship of the donor and the recipient should not alter the level of acceptable risk.  
12

13 3. There should be a cooling-off period between consent and the actual donation procedure.  
14

15 4. Non-English speaking candidates and hearing-impaired candidates should be provided with a  
16 non-family interpreter.

17  
18 5. A member of the donor advocate team should witness the potential donor’s signing of a  
19 consent document.  
20

21 The overall donation experience should be explained to the potential donor and should  
22 include:

23 1. donor evaluation procedure;

24 2. surgical procedure;

25 3. recuperative period;

26 4. short- and long-term follow-up care;

27 5. alternative donation and transplant procedures;

28 6. potential benefits to donor ( psychological);

29 7. transplant center and surgeon-specific statistics of donor and recipient outcomes;

30 8. confidentiality of the donor’s information and decision;

31 9. donor’s ability to opt out at any point in the process.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32

## **C. Risks**

Risks should be fully explained to the potential donor.

### **1. Physical**

- a. potential for surgical complications including risk of donor death;
- b. potential for liver failure and the need for liver transplant;
- c. possible medical complications including potential for long-term complications;
- d. scars;
- e. pain;
- f. fatigue;
- g. abdominal and/or bowel symptoms such as bloating and nausea.

### **2. Psychological**

- a. potential for problems with body image;
- b. possibility of recipient death;
- c. possibility of recipient rejection and need for retransplantation;
- d. possibility of recurrent disease in recipient such as hepatitis C or hepatocellular carcinoma;
- e. possibility of adjustment disorder postsurgery;
- f. impact on donor’s family;
- g. impact on recipient’s family.

### **3. Social**

- a. potential impact of donation on lifestyle;
- b. potential impact on ability to obtain future employment.

### **4. Financial**

- a. out-of-pocket expenses for insurance;
- b. child care costs;
- c. possible loss of employment costs
- d. potential for disability benefit needs and need for assistance completing relevant paperwork;

**DRAFT –October 18, 2002**

1 e. impact on ability to obtain health and life insurance (may be denied or have high  
2 future premiums).

3  
4  
5 **D. Choice**

- 6 1. Determine that there is no monetary compensation for the donor.  
7 2. Determine that there is no coercion to donate by family or others.  
8 3. Assist donor with medical excuse or general statement of unsuitability for donation if  
9 requested by donor.  
10 4. Medical information on donor should not be falsified to provide the donor with an excuse  
11 declining donation.  
12 5. Donor should be able to balance risk and benefit.  
13 6. Recipient should be aware of and accept the risks to the donor.  
14 7. Donor should understand that he or she may decline to donate at any time.

15  
16  
17 **E. Documentation**

- 18 1. Disclosure and consent process should be documented.  
19 2. Donor should have a medical record separate from the recipient's to protect donor  
20 confidentiality.

21  
22  
23 **F. Decision to Donate**

24 Once the independent donor advocate team determines the suitability of the donor, then,  
25 further evaluative processes may proceed: medical assessment, psychological assessment,  
26 assessing the family dynamics, and assessing the level of social support.

- 27  
28 1. If the potential donor wishes to donate, but the independent advocate team does not agree, the  
29 donation should not occur.  
30  
31 2. If the independent advocate team and the potential donor agree to donate, final review rests  
32 with the transplant team.

## V. EVALUATION

### A. Primary Medical Evaluation

A medical evaluation of the potential donor should be made by a senior member of the medical staff to diminish the susceptibility to covert pressure. The following are recommended minimal initial criteria before proceeding with further evaluation:

1. absence of systemic disease or its likely occurrence (for example, consider genetic and environmental vulnerability);
2. absence of current or past impairment to any vital organ (for example, mild chronic obstructive pulmonary disease or history of coronary artery disease); when appropriate a liver biopsy should be performed to determine the presence of nonseropositive hepatitis and steatohepatitis;
3. absence of special vulnerability to infection, blood loss, or delayed wound healing; because of the risk of peptic ulcer disease in the donor, a significant documented history of peptic ulcer disease should be considered a contraindication.

### B. Psychiatric and Social Requirements

The transplant center should have a designated psychiatrist or psychologist or a general hospital psychiatric group. These individuals should be skilled as liaisons for the donation process and be familiar with the relevant literature on psychiatric aspects of consultation and knowledge of where to turn for additional information or guidance.

1. Good samaritan donation is not recommended. Although this may change in the future, the risks and benefits of right lobe donation are not sufficiently determined to justify good samaritan donation. Live donor adult liver donation is distinct from living donor kidney and left lateral segmentectomy donation.

**DRAFT –October 18, 2002**

- 1 2. There should be no coercion by those close to the donor or recipient.  
2
- 3 3. The donor should be of legal age and financially and emotionally independent from his or her  
4 family and the recipient.  
5
- 6 4. The donor should be free of current psychiatric disorders. In situations where a past history of  
7 psychiatric illness exists, the illness should be in full remission as documented by a  
8 psychiatric evaluation.  
9
- 10 5. There should be no evident profit motive in the donor’s participation  
11
- 12 6. The donor should not have a history of physical or sexual abuse unless the recipient’s survival  
13 is essential to donor welfare (for example, a twin brother and sister have experienced  
14 childhood abuse and suffer from stress disorders, but depend on each other for emotional  
15 sustenance).  
16
- 17 7. The donor should be able to acknowledge and understand the attendant risks of live donor  
18 adult liver transplantation and there should be appropriate documentation of that  
19 acknowledgement.  
20
- 21 8. If the donor has a history of alcohol addiction, there should be evidence of long-term stable  
22 abstinence with low risk of exacerbation.  
23
- 24 9. The donor should have the right and the capacity to withdraw participation at any time prior to  
25 the surgery.

**VI. LIVER TRANSPLANT RECIPIENTS**

A patient being considered as a recipient of a live adult liver donation should meet the eligibility criteria to be listed on the cadaveric transplant waiting list. The standard United Network for Organ Sharing (UNOS) recipient criteria for transplantation should be supplemented by the following exclusions for living liver transplantation (These exclusions may change as more data become available.):

- A. a model for end-stage liver disease (MELD) score of greater than 25;
- B. adult fulminate failure;
- C. cholangio carcinoma;
- D. hepatocellular carcinoma if:
  - 1. the tumor is a nonresponder after treatment;
  - 2. there is evidence of metastatic disease;
  - 3. comorbidities exist;
  - 4. the recipient can expect less than a one-year disease-free outcome.
- E. retransplantation for hepatitis C;
- F. need for renal dialysis;
- G. someone who needs a combined liver/kidney transplant;
- H. acute alcoholic hepatitis.

Information that should be provided for the recipient includes:

- A. specific risks and benefits;
- B. alternative treatments available;
- C. expected outcome of transplantation.

## VII. PERIOPERATIVE CARE AND FACILITY SUPPORT

The donor surgeon should have primary concern and responsibility for the donor’s (not the recipient’s) welfare throughout the entire hospital stay.

### A. Preoperative Preparation

1. All donors should bank a minimum of one unit of blood before surgery. Facilities should have the ability to handle autologous blood donations.
2. Surgeries should be scheduled only when sufficient staffing will be available for the postoperative period (preferably the early part of the week). If surgery is scheduled during the latter part of the week, the hospital should ensure that there is adequate attending physician and nursing coverage during the weekend.

### B. Operative Teams

1. There should be two liver transplant attending surgeons with live donor adult liver transplantation experience attending the live donor procedure. One such surgeon should be present for the entire procedure and both of these surgeons should be scrubbed and present for the critical portions of the procedure.
2. A third liver transplant attending surgeon should be present in the recipient operating room. This surgeon should have experience in cadaveric liver transplantation but does not necessarily need expertise in live donor resectional surgery.

### C. Qualifications of Surgical Team

#### Surgeons

**DRAFT –October 18, 2002**

- 1 1. All three surgeons should be board certified in general surgery or an equivalent foreign  
2 certification acceptable to the New York State Department of Health.  
3
- 4 2. All three surgeons should have demonstrated experience in liver transplant surgery.  
5
- 6 3. All three surgeons should have demonstrated experience in living donor hepatectomy (15  
7 procedures) or demonstrated experience in major hepatobiliary resectional surgery (20  
8 procedures) or surgical fellowship at an American Society of Transplant Surgeons (ASTS)  
9 approved liver transplant fellowship program with demonstrated experience (15 procedures)  
10 with the live donor hepatectomy procedure. This should include written verification by the  
11 fellowship program director or by the director of the supervising transplant program of hands-  
12 on training at an institution performing live donor hepatectomy.  
13
- 14 4. For a new program with no experience in live donor adult liver transplantation, surgeons  
15 should have demonstrated experience in major hepatobiliary resectional surgery (20  
16 procedures). Surgeons should also visit an established program and observe a minimum of  
17 five cases. Written verification should be obtained from the director of the hosting program.  
18
- 19 5. Two liver transplant-attending surgeons with live donor liver resectional experience should  
20 operate on the donor. These two surgeons should be present for the critical parts of the surgery  
21 including the liver parenchymal transection. They should be available and scrubbed if needed  
22 for complications, however, only one surgeon need be present for the remainder of the donor  
23 operation. One experienced surgeon and a resident or a fellow operating on the donor during  
24 the critical parts of the surgery would not be acceptable.  
25

**Anesthesia**

- 27 1. There should be two separate anesthesia-attending physicians for the live donor adult liver  
28 transplantation. These anesthesia attendings should be present for the critical anesthetic and  
29 surgical portions of the procedures and immediately available at all other times. As one case is  
30 completed, either anesthesia attending can take responsibility for the ongoing case. The  
31 anesthesia attendings should have experience in liver transplant anesthesia and/or major  
32 hepatic resection surgery and/or cardiac surgery anesthesia.  
33
- 34 2. There should be two separate anesthesia teams in two operating rooms (one for the donor, one  
35 for the recipient).

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32

3. These teams should be directed by a separate anesthesia attending for the live donor and the recipient procedure. They should have ongoing education and training in liver/cardiac surgery and have had anesthesia responsibility for major liver resections. The attendings do not have to be in the room at all times, but should be present for critical times and for all other times, be immediately available if needed. Fellows and or chief residents (postgraduate year 4 or 5) and qualified certified registered nurse anesthetists (CRNAs) may also fulfill these roles.

**D. Postoperative Care**

1. Day 0-1: Living adult liver donors should receive intensive care (ICU or PACU).
2. Day 2: If stable and cleared for transfer by the transplant team, donors should be cared for in a hospital unit that is dedicated to the care of transplant recipients or a hospital unit in which patients who undergo major hepatobiliary resectional surgery are cared for. Liver donors should not at any time be cared for on any other unit unless a specific medical condition of the donor warrants such a transfer.
3. The donor should be evaluated at least daily by one of the qualified liver transplant attendings with documentation in the medical record.
4. The transplant team should be responsible for the pain management of the donor. In institutions where a pain management team is available, the transplant team may delegate its responsibility to this team. However, there should be a written protocol in place for assessment and management of donor pain.
5. There should be an identified member of the anesthesia care team, with specific education and training in pain management of liver donors, who is available for consultation with the transplant team regarding the pain control of the donor.
6. Since Day 3 and 4 are generally the time complications might occur (for example, gastric dilatation, wound infections, severe hypophosphatemia), the patient care staff should be

**DRAFT –October 18, 2002**

1 familiar with the common complications associated with the donor and recipient operations  
2 and have appropriate monitoring in place to detect these problems should they arise.

3

4 7. If there is an emergent complication requiring re-operation, these patients should be  
5 prioritized for access to the operating room.

6

7

8 **E. Medical Staffing**

9 1. There should be 24 hour/seven day-a-week continuous coverage of the transplant service by  
10 general surgery residents at the postgraduate year 2 level or higher, transplant fellows, or  
11 physician extenders (nurse practitioners or physician assistants). Between the hours of 6 p.m.  
12 and 7 am and at all times on weekends and holidays, the covering residents, fellows, nurse  
13 practitioners, or physician assistants should be dedicated to the liver transplant service and not  
14 covering other surgical and non-surgical patients. An attending transplant surgeon should be  
15 available as a resource for the residents, fellows, or physician extenders at all times.

16

17 2. Any patient with abnormal vital signs or unusual symptoms as identified by the registered  
18 nurse should be evaluated immediately. Notification to the appropriate senior medical staff  
19 (fellow, chief resident, attending) should be made within 30 minutes. Facilities should have  
20 policies in place to assure this process occurs in an expedient manner.

21

22

23 **F. Nursing Staffing**

24 1. Nursing staff should have ongoing education and training in living liver transplantation  
25 nursing care (donor and recipient). This should include education on the pain management  
26 issues particular to the donor. The registered nursing ratio should be 1:2 in the ICU/PACU  
27 level setting, adjusted as appropriate for the acuity level of the patients.

28

29 2. The registered nursing ratio should be 1:4 in the floor transplant unit on all shifts, adjusted as  
30 appropriate for the acuity level of the patients.

31

**DRAFT –October 18, 2002**

1 3. The same registered nurse should not take care of both the donor and the recipient. This will  
2 minimize confusion if the surnames of the two are the same and will allow the nurse to focus  
3 solely on the needs of either the donor or the recipient.

4  
5 4. The nursing service should provide the potential donor with presurgical information including  
6 a tour of the unit before surgery, if possible.

7  
8 5. The names and beeper numbers of the transplant team should be posted on all units receiving  
9 transplant donors.

10  
11

**G. Radiology**

13 1. The radiologist should have demonstrated training in evaluating preoperative imaging studies  
14 of a potential liver donor computerized tomography [CT scan] and/or magnetic resonance  
15 imaging [MRI] with respect to liver volume estimates (right and left lobe) and detailed  
16 vascular anatomy.

17  
18 2. The radiologist should have expertise in reviewing imaging studies in liver transplant  
19 recipients.

## VIII. DISCHARGE PLANNING

The Committee recommended a comprehensive survey of all donors in New York State to more fully understand issues surrounding donation and particularly to identify ways to improve the discharge planning process and the posthospital experience. The surveys were mailed by each transplant center in October 2002. Donors were provided with business reply envelopes addressed to the New York State Department of Health where a confidential analysis is underway. (See Appendix 2 for a copy of the survey.)

### A. Predonation

1. Discharge planning should be viewed as a comprehensive process beginning with the decision to donate.
2. The independent donor advocacy team should be available to provide support to the donor from preadmission to postdischarge as outlined in this report.
3. The potential donor should be referred to others who have donated in the past.

### B. Discharge Plan

1. A written discharge protocol should be developed and made available to all health care professionals involved in the care of the patient as well as given to the patient.
2. This plan should be reviewed with the patient by a health care professional designated by the program, such as the primary care nurse, social worker, or transplant coordinator.
3. Instructions should include:
  - a. restrictions on activities (no heavy lifting for one month, no driving for four weeks, etc.);
  - b. activities permitted (showering, walking, other activities as tolerated);
  - c. diet (in most cases will be regular);
  - d. medication for pain;

**DRAFT –October 18, 2002**

- 1 e. wound care;
- 2 f. a 24-hour contact number that patients can call with questions, concerns, and/or problems;
- 3 this contact person should be available when needed and be knowledgeable about live
- 4 adult liver donation;
- 5 g. name, address, and telephone number of the surgeon and instructions for the follow-up
- 6 visit; and
- 7 h. instructions for family members or caregivers.

8  
9

**C. Postdischarge**

- 10 1. Medical follow-up should be appropriate for someone who has undergone a major liver
- 11 resection procedure. This follow-up should include:
- 12
  - 13 a. postoperative visits with the transplant surgeon;
  - 14
  - 15 b. follow-up coordinated with the patient’s primary care physician to assess wound
  - 16 healing, monitor for signs/symptoms of infections, and monitor liver function;
  - 17
  - 18 c. standardized assessment of liver function and morphology over time (while this is
  - 19 important, a standard of care has not yet emerged and practice will be developed
  - 20 within the centers);
  - 21
  - 22 d. written summary of the patient’s condition which should be provided to the patient and
  - 23 his or her primary care physician upon the patient’s discharge from the hospital; this
  - 24 will ensure continued appropriate medical care of the patient.
  - 25
- 26 2. Follow-up social/psychological supports which may include measures such as:
- 27
  - 27 a. visits with a social worker;
  - 28 b. visits with a psychologist or psychiatrist;
  - 29 c. participation in a professionally run support group, similar to support groups for
  - 30 cadaveric donor families;
  - 31 d. participation in a center-sponsored computer donor listserve or bulletin board to share
  - 32 patient concerns;

**DRAFT –October 18, 2002**

1 e. invitation to a donor recognition event, such as an annual recognition ceremony or  
2 presentation of a donor medal.

3

4 3. Follow-up on financial/insurance concerns, possibly by the transplant center’s financial  
5 coordinator.

6

7 Establishment of a data collection system to track and analyze the long-term outcomes of  
8 live adult liver donation in New York State. Adult liver donors should be followed for at least two  
9 years postdonation to determine if there are any long-term health issues associated with the  
10 donation. This data system should be available to the New York State Department of Health at all  
11 times. (See Appendix 1 for the data collection instrument in use by the New York Center for  
12 Liver Transplant.)

1 APPENDIX 1: NYCLT ONLINE DATA COLLECTION INSTRUMENT

2

3 **New York Center for Liver Transplantation, Inc. (NYCLT)**  
4 **Live Liver Donor Tracking Form.**

5 7.8.2002

6 **Provider Information**

[LOGOUT](#)

**Provider Information.**

NYCU  NYWC  NYCP  NYFL  NYMS

3 Month Report

1 Year Report

**Date of check up.**

(mm/dd/yyyy)

7

8 **Donor Information**

**Donor Social Security Number.**

**UNOS Identifier.**

**Date of Birth.**

(mm/dd/yyyy)

**Donor Gender.**

Male  Female

**Is Donor related to recipient?**

Yes  No

**Does Donor have health insurance?**

Yes  No

9

10 **Surgery Information**

**Date of hepatectomy.**

(mm/dd/yyyy)

**Type of resection.**

Left Lateral Segments

**DRAFT –October 18, 2002**

Left Lobe

Right Lobe

Length of Donor hospitalization stay.  (in days)

**Was donor readmitted to hospital after initial discharge?**

Yes  No

**If yes, indicate reason and date of readmission:**

Wound Infection  
Date: (mm/dd/yyyy)

Fever  
Date: (mm/dd/yyyy)

Bowel obstruction  
Date: (mm/dd/yyyy)

Pleural Effusion  
Date: (mm/dd/yyyy)

Dehydration  
Date: (mm/dd/yyyy)

Ileus  
Date: (mm/dd/yyyy)

Dehiscence  
Date: (mm/dd/yyyy)

Portal vein thrombosis  
Date: (mm/dd/yyyy)

Intrabdominal abcess  
Date: (mm/dd/yyyy)

Other:   
Date: (mm/dd/yyyy)

**Was procedure aborted after Donor received anesthesia?**

Yes  No

**If yes, please indicate reason?**

- Cardiac Issues
- Anesthesia Issues
- Donor anatomy Issues
- Recipient Issues
- Other

**Non-autologous blood administration intra-operative:**

Yes  No

**If yes, please indicate number of PRBC units donor received.**

\_\_\_\_\_

**Donor Complications**

**Did Donor have any biliary complications?**

Yes  No

**If yes, please indicate type of biliary complication.**

- Grade 1 – Prolonged JP drainage (more than 7days)
- Grade 2 – Interventional procedure (ERCP, PTC)
- Grade 3 – Surgical intervention

**Did Donor have a biliary stricture?**

Yes  No

**Did Donor experience post operative bleeding?**

Yes  No

**If yes, please indicate number of PRBC units Donor received.**

\_\_\_\_\_

**Did Donor experience any vascular complications?**

1  
2  
3

Yes  No

**If yes, please indicate type(s) of vascular complication:**

- Portal Vein
- Hepatic Vein
- Hepatic Artery
- Pulmonary Embolus
- Deep Vein Thrombosis
- Other:

**Did the patient experience any other complications?**

Yes  No

**If yes, please indicate type of complication.**

- Anesthesia related
- Line or IV Complication
- Pulmonary  
(pneumonia/reintubation/pleural effusion)
- Wound complication  
(infection, hernia, chronic abd pain)
- Brachial nerve injury
- Other:

**Did Donor have to have a re-operation?**

Yes  No

**If yes, please indicate type of operation and associated date.**

Liver Failure req. transplant

Date:

Bleeding

Date:

Biliary

Date:

Hernia Repair

Date:

Bowel obstruction

Date:

Vascular  
Date:

Other:

---

**Did Donor have any other interventional procedures?**

Yes  No

**If yes, please indicate type and date(s) of intervention procedure.**

1.  Date: (mm/dd/yyyy)

2.  Date: (mm/dd/yyyy)

---

1 **Mortality**

**Mortality?**

Yes  No

**If yes, indicate cause and date of Donor death.**

30 (chars left)

2  
3

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

September 2002

**Urethrolysis**

The CPT Editorial Panel created one new code 53500, *Urethrolysis, transvaginal, secondary, open (e.g. postsurgical obstruction scarring)*, to describe urethrolysis. Urethrolysis is a distinct operative procedure reserved for women who have undergone a prior urethral suspension procedure and have subsequently developed excessive periurethral scarring and obstructive voiding symptoms. Current codes do not capture the operative technique and work involved in dissecting and mobilizing the urethra away from the dense surrounding fibrous tissue.

The specialty society surveyed 79 physicians who perform the procedure and a majority of the respondents indicated that the key reference service code should be CPT code 57287, *Removal or revision of sling for stress incontinence (eg, fascia or synthetic)* (RVU=10.71). The survey median for urethrolysis was 14.06, substantially higher than the RVU for the reference service code. However, physician work for the new code was consistently identified as being more intense and more complex than that of sling removal or revision, also reflected by the longer intra-service time for urethrolysis (90 minutes) when compared to the reference service code intra-service time (70 minutes). After review of the data, the RUC and the specialty society determined that the 25<sup>th</sup> percentile RVW (12.21) accurately reflected the actual work performed in comparison to the key reference service. **The RUC recommends a relative work value of 12.21 for CPT code 53500.**

CMS recommended that the specialty society provide a letter to Administar regarding the use of cystourethroscopy. The Correct Coding Initiative may require that an edit to appropriately indicate that cystourethroscopy should not be reported in addition to Code 53500. The RUC requests that specialty society work with CPT to editorially revise the description of the code to include that the procedure cystourethroscopy is included in this services and should not be reported separately. *Staff Note: Editorial changes to the descriptor were accepted by the CPT Editorial Panel at the November 2002 CPT Meeting.*

Practice Expense

The RUC accepted the practice expense inputs as submitted, which are based on the standard 090-day global practice expense inputs.

CPT Code (•New)	Track ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●53500	A1	Urethrolisis, transvaginal, secondary, open, including cystourethroscopy (e.g. postsurgical obstruction scarring)  (For urethrolisis by retropubic approach, use 53899)  (Do not report 53500 in conjunction with 52000)	090	12.21

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: 53500 Tracking Number: A1 Global Period: 090 Recommended RVW: 12.21**

**CPT Descriptor:** Urethrolisis, transvaginal, secondary, open, including cystourethroscopy (e.g. postsurgical obstruction scarring) (For urethrolisis by retropubic approach, use 53899)

(Do not report 53500 in conjunction with 52000)

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:**

A 62 year old female is 1 year following a bladder neck suspension. She has developed progressive urinary obstructive symptoms including decreased force of stream, straining to void and double voiding. Work up demonstrates significant bladder outlet obstruction secondary to urethral scarring and fibrosis. After discussion and counseling with her surgeon, the patient elects to have an open transvaginal urethrolisis performed.

**Description of Pre-Service Work:**

**Pre-service Work- Day before surgery:**

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be faxed to hospital)

**Pre-service work- Day of surgery:**

- Change into scrub cloths
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on operating table
- Verify that all necessary instruments are available

**Description of Intra-Service Work:**

- The patient is placed in the lithotomy position, a 16 F Foley catheter placed in the bladder
- A vaginal incision is made
- The periurethral and vesicovaginal space is dissected special care being taken to avoid injury to the urethra and bladder neck
- Dissection is carried anterior and posterior to the urethra until the urethra has been freed from the surrounding structures
- Dissection, lysis, or removal of associated fibrosis is performed
- Meticulous hemostasis is done to prevent refibrosis of the urethra
- The incision is closed in multiple layers depending on the integrity of the urethra following release of the fibrosis
- A vaginal pack is gently positioned, the Foley catheter is left in place, drains may be placed

**Description of Post-Service Work:****Post-op Same day work through discharge from recovery**

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative report
- Check dressings, drain and surgical site

**Post-op Same day work after discharge from recovery**

- Examine patient, check wound and patient progress
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record
- Research and identify appropriate ICD-9 and CPT codes for billing
- *The patient may be admitted to the hospital or discharged home depending on the particular requirements of each patient*

**Post-op Other Hospital Work – Beginning on post op-day 1, until discharge day**

- Examine and talk to patient
- Check wounds and dressings
- Check drain, decide when to remove
- Discuss patient progress with patient and family
- Review all patient hospital medical record notes
- Discuss post operative care of wound at home
- Answer nursing and other staff questions
- Answer patient and family questions
- Write orders in medical record
- Write progress notes

**Discharge day work:**

- Examine and talk with patient and family
- Check wounds and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Discuss post-op care of wound with patient and family
- Dictate detailed hospital discharge summary

**Post-op Office work- After discharge from hospital:**

- Examine patient, check vital signs
- Talk with patient and family

- Answer questions from patient and family
- Write necessary prescriptions
- Remove sutures/drains/catheter as may be indicated
- Schedule next office visit
- Mark appropriate diagnosis and CPT code on Superbill
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

**SURVEY DATA:**

Presenter(s) James B. Regan, M.D.

Specialty(s): Urology

Sample Size: 79 Response Rate: (%): 39% Median RVW: 14.06

Type of Sample: **Panel** Explanation of sample size: The AUA sent an email to urologists in its member database who had identified incontinence as one of their urological subspecialties asking them if they performed urethrolysis and would be willing to fill out a survey. Based on responses from this email, we sent out 79 surveys and received 31 usable surveys.

	Low	25 <sup>th</sup> %	Median	75 %	High
<b>Survey RVW</b>	6.80	12.21	14.06	15.00	22.00
<b>Pre-Service Time</b>	10	30	50	90	180
<b>Intra-Service Time</b>	30	60	90	120	180

Post-Service:	Total Time	# of visits & CPT code
<b>Immed. Post-Service</b>	29	
<b>Critical Care</b>		
<b>Other Hospital</b>		1-99231
<b>Discharge Day Mgmt</b>		1-99238
<b>Office Visits</b>		2-99213 1-99212

**KEY REFERENCE SERVICES:**

<u>CPT</u>	<u>Descriptor</u>	<u>2002 RVW</u>	<u>% RESP</u>	<u>GLOBE</u>
57287	Removal or revision of sling for stress incontinence (eg, fascia or synthetic)	10.71	39	090
57288	Sling operation for stress incontinence (eg, fascia or synthetic)	13.02	26	090
53445	Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff	14.06	13	090

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

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

**TIME ESTIMATES (Median)**

**New/Revis. Key  
CPT Code: Reference  
CPT Code:  
57287**

Median Pre-Time	50	45
Median Intra-Time	90	70
Median Immediate Post-service Time	30	30

Median of Aggregate Critical Care Times	0	0
Median of Aggregate Other Hospital Visit Times	19	38
Median Discharge Day Management Time	36	36
Median of Aggregate Office Visit Times	61	61

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.06	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.23	3.31
Urgency of medical decision making	2.87	2.62

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.32	3.69
Physical effort required	3.65	3.31

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.97	3.19
Outcome depends on the skill and judgement of physician	4.29	3.77
Estimated risk of malpractice suit with poor outcome	3.94	3.50

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**    **Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.84	3.32
Intra-Service intensity/complexity	4.00	3.75
Post-Service intensity/complexity	3.32	3.18

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

AUA surveyed 79 members who performed the procedure and indicated they would be willing to complete a survey. A slight majority of the survey respondents chose CPT code 57287, sling reversal, as the key reference service. The survey median RVWs for urethrolysis (14.06) came out to be substantially higher than those for the reference code (10.71). However, they consistently identified the physician work for urethrolysis as being more intense and more complex than that of the sling reversal; this is also reflected in the longer intraservice time for the new code when compared to the reference code. After review and discussion of the survey data, AUA's Physician Payment Review workgroup decided to recommend the 25<sup>th</sup> percentile RVWs (12.21). The workgroup believes that this number more accurately reflected the actual work performed in comparison to the key reference service.

### SERVICES REPORTED WITH MULTIPLE CPT CODES

Is this new/revised code typically reported on the same date with other CPT codes? **NO**

---

### FREQUENCY INFORMATION

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

53899- Unlisted procedure, urinary system

57287- Removal or revision of sling for stress incontinence (eg, fascia or synthetic)

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

Specialty **Urology**                             Commonly   **X**   Sometimes        Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty **Urology**                      Frequency   **5,000**  

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

Specialty **Urology**                      Frequency   **1,200**  

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

	A	B	C	D
1			FAMILY 1	
2			53500 Cystourethroscopy, transurethral, secondary, open, including cystourethroscopy (e.g. postsurgical obstruction scarring) (For urethrolisis by retropubic approach, use 53899)(Do not report 53500 in conjunction with 52000)	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		
4	LOCATION		In Office	Out Office
5	GLOBAL PERIOD			90
6	TOTAL CLINICAL LABOR TIME	1130	0.0	171.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		0.0	60.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		0.0	12.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		0.0	99.0
10	PRE-SERVICE			
11	Start: Following visit when decision for surgery or procedure made			
12	Complete pre-service diagnostic & referral forms			5
13	Coordinate pre-surgery services			20
14	Schedule space and equipment in facility			8
15	Office visit before surgery/procedure Review test and exam results			
16	Provide pre-service education/obtain consent			20
17	Follow-up phone calls & prescriptions			7
18	Other Clinical Activity (please specify)			
19	End:When patient enters office/facility for surgery/procedure			
20	SERVICE PERIOD			
21	Start: When patient enters office/facility for surgery/procedure			
22	Pre-service services			
23	Review charts			
24	Greet patient and provide gowning			
25	Obtain vital signs			
26	Provide pre-service education/obtain consent			
27	Prepare room, equipment, supplies			
28	Prepare and position patient/ monitor patient/ set up IV			
29	Sedate/apply anesthesia			
30	Intra-service			
31	Assist physician in performing procedure			
32	Post-Service			
33	Monitor pt following service/check tubes, monitors, drains			
34	Clean room/equipment by physician staff			
35	Complete diagnostic forms, lab & X-ray requisitions			
36	Review/read X-ray, lab, and pathology reports			
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			
38	Coordination of Care			
39	Discharge day management 99238 –12 minutes 99239 –15 minutes			12
40	Other Clinical Activity (please specify)			
41	End: Patient leaves office			
42	POST-SERVICE Period			
43	Start: Patient leaves office/facility			
44	Conduct phone calls/call in prescriptions			
45	Office visits Greet patient, escort to room, provide gowning, interval history & vital signs and chart, assemble previous test reports/results, assist physician during exam, assist with dressings, wound care, suture removal, prepare dx test, prescription forms, post service education, instruction, counseling, clean room/equip, check supplies, coordinate home or outpatient care			
46	List Number and Level of Office Visits			
47	99211 16 minutes	16		
48	99212 27 minutes -1	27		27
49	99213 36 minutes - 2	36		72
50	99214 53 minutes	53		
51	99215 63 minutes	63		
52	Other			
53				
54	Total Office Visit Time		0	99
55	Other Activity (please specify)			
56	End: with last office visit before end of global period			

	A	B	C	D
2			53500	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	secondary, open, including cystourethroscopy (e.g. postsurgical obstruction scarring) (For urethrolisis by retropubic approach, use 53899)(Do not report 53500 in conjunction with 52000)	
4	LOCATION		In Office	Out Office
57	<b>MEDICAL SUPPLIES</b>			
58	catheter insertion kit	93102		1
59	depends	11114		3
60	multispecialty minimum supply package			3
61	patient education booklet	11115		1
62	post-op incision care kit			1
63	sani wipes	11113		3
64	suture removal kit	31703		1
65				
66				
67	<b>Equipment</b>			
68	Power table	E11003		1
69	light source	E13122		1
70				
71				
72				
73				

AMA/Specialty Society RVS Update Committee  
 Summary of Recommendations  
 April 2003

**Laparoscopic Colpopexy**

CPT created a new code to specifically describe the laparoscopic approach to correct female pelvic support defects. This laparoscopic method is becoming more widespread due to the increasing laparoscopic surgical skills of physicians. The RUC compared the new code 57425 *Laparoscopy, surgical, colpopexy (suspension of vaginal apex)* to code 57280 *Colpopexy, abdominal approach* ( work RVU = 15.04). The RUC agreed with the presenters that the new code is very similar to the reference code. The surveyed code requires more physical effort than the reference code but the reference code has an easier post-op management period. The presenters stated that these two factors balance each other out and result in the two codes being essentially the same procedure. The survey respondents ranked the laparoscopic code higher in each of the intensity/complexity measures. While it is generally the same procedure, there are elements of laparoscopic surgery that justify a slightly higher RVW value for the surveyed code in comparison to the reference code.

- Laparoscopic surgery does not have the reduced intensity during opening and closing, as do abdominal surgeries.
- Laparoscopic surgery requires the development of specialized skills .
- Laparoscopic surgery requires the physician to view their surgical environment using cameras and other technology

To ensure proper rank order, the RUC accepted the 25th percentile RVU of 15.75. In addition, the RUC agreed with the presenters proposal to reduce the pre-service time from the surveyed time of 85minutes to 60 minutes. Using this reduced pre-service time, which matched the reference service pre-service time, produced an IWPUT consistent with the reference service.

**The RUC recommends a work RVU of 15.75 for code 57425.**

**Practice Expense**

The RUC accepted the standard packages for 90 day global procedures.

CPT Code (●New)	Track ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●57425	CC1	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)	090	15.75

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

---

CPT Code: 57425      Tracking Number: CC1 Global Period: 090    Recommended RVW: 15.75

CPT Descriptor: Laparoscopy, surgical, colpopexy (suspension of vaginal apex)

---

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey:

A 63-year-old sexually active G5P5 underwent abdominal hysterectomy twenty years ago for leiomyomata. She developed a symptomatic cystocele and rectocele and was treated with anterior and posterior repair 3 years ago. Now she is being evaluated for pelvic and vaginal pressure-like discomfort and tissue prolapsing through the introitus. Examination documents prolapse of the vaginal vault through the introitus and good anterior and posterior support. A colpopexy is required. The physician is trained in operative laparoscopy and a laparoscopic approach is planned.

Percentage of Survey Respondents who found Vignette to be Typical: 100% (25/25)

Description of Pre-Service Work:

- Paperwork for hospital admission
- Perform interval history and physical examination
- Review records
- Review and obtain operative consent
- Check instrumentation and materials
- Position patient after induction of anesthesia
- Scrub, gown and glove

Description of Intra-Service Work:

- “Y-“ Graft is prepared by suturing two pieces of mesh.
- Standard laparoscopic entry into peritoneal cavity.
- Inspection and exploration of abdominal cavity.
- Placement of vaginal probe for manipulation of vault.
- Adhesiolysis to gain access to the vaginal apex.
- Peritoneum incised over vaginal apex.
- Vesicovaginal space is developed and bladder is mobilized inferiorly exposing pubocervical fascia anteriorly.
- Rectovaginal space is developed and rectum is mobilized inferiorly exposing rectovaginal fascia posteriorly.

- Culdeplasty (Halban or McCall) is performed to obliterate cul de sac preventing future bowel entrapment.
- Graft is secured anteriorly and posteriorly to pubocervical and rectovaginal fascia respectively.
- Peritoneum overlying sacral promontory opened and extended down to superior margin of culdeplasty.
- Presacral dissection to expose anterior longitudinal ligament of the sacrum.
- Presacral vessels are carefully ligated.
- Graft is “sized” and secured to anterior longitudinal ligament of the sacrum.
- Peritoneum is closed over entire graft to prevent internal hernia and mesh adhesion to bowel.
- Trocar sites closed at fascia.
- Skin incisions closed.

Description of Post-Service Work:

- Accompany patient to recovery room
- Write orders
- Speak with family
- Dictate operative note
- Observe patient in recovery until stable
- See and evaluate patient in the hospital for two visits +discharge
- Office evaluation and management for two post-op visits

**SURVEY DATA**

<b>Presenter(s):</b>	George Hill, MD, FACOG/Vincente Lucente, MD, FACOG/Sandra Reed, MD, FACOG				
<b>Specialty(s):</b>	American College of Obstetricians and Gynecologists (ACOG) American Association of Gynecologic Laparoscopists (AAGL)				
<b>CPT Code:</b>	57425				
<b>Sample Size:</b> 58	<b>Resp n:</b> 25	<b>Resp %:</b> 43%			
<b>Sample Type:</b>					
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	14.00	15.75	17.04	18	38.08
<b>Pre-Service Evaluation Time:</b>	10	50	60	65	130
<b>Pre-Service Positioning Time:</b>	5	10	10	15	30
<b>Pre-Service Scrub, Dress, Wait Time:</b>	10	15	20	30	30
<b>Intra-Service Time:</b>	60	90	120	150	280
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b>30</b>				

<b>Critical Care time/visit(s):</b>	<b><u>N/A</u></b>	
<b>Other Hospital time/visit(s):</b>	<b><u>60</u></b>	<b><u>2 - 99232</u></b>
<b>Discharge Day Mgmt:</b>	<b><u>36</u></b>	<b><u>99238</u></b>
<b>Office time/visit(s):</b>	<b><u>46</u></b>	<b><u>2-99213</u></b>

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

---

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
57280	Colpexy, abdominal approach	090	15.04

---

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

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

Number of respondents who choose Key Reference Code: 20/25

<u>TIME ESTIMATES (Median)</u>	<u>New/Revis. CPT Code SURVEY: <u>5742X</u></u>	<u>ACOG RECOMMEN DATION: <u>5742X</u></u>	<u>Key Reference CPT Code: <u>57280</u></u>
Median Pre-Service Time	85*see rationale	<b>60*</b> see rationale	60
Median Intra-Service Time	120	120	115
Median Immediate Post-service Time	30	30	45
Median Critical Care Time	0	0	0
Median Other Hospital Visit Time	60	60	109
Median Discharge Day Management Time	36	36	36
Median Office Visit Time	46	46	46
Median Total Time	377	352	411

**INTENSITY/COMPLEXITY MEASURES (Mean)**
**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.25	4.11
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.79
Urgency of medical decision making	2.85	2.74

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.95	4.16
Physical effort required	4.60	4.16
<b>Psychological Stress (Mean)</b>		
The risk of significant complications, morbidity and/or mortality	4.45	4.21
Outcome depends on the skill and judgement of physician	4.90	4.21
Estimated risk of malpractice suit with poor outcome	4.16	3.83

**INTENSITY/COMPLEXITY MEASURES****CPT Code**      **Reference Service 1**

5742X                      57280

**Time Segments (Mean)**

Pre-Service intensity/complexity	4.17	4.06
Intra-Service intensity/complexity	4.94	4.12
Post-Service intensity/complexity	3.39	3.53

**ADDITIONAL RATIONALE**

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

**SURVEY METHOD**

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey to a targeted mailing list of 58 members of AAGL and ACOG. Twenty-five surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted final recommendations.

**PANEL RECOMMENDATION**

The Panel makes the following recommendations to the RUC:

1. Physician Work Recommendation – 15.75 – the 25<sup>th</sup> percentile
2. Pre-Service Time – reduce from the surveyed time of 85 minutes to 60 minutes

**PANEL DISCUSSION**

The panel developed the recommendation in the following manner:

1. Comparing the surveyed code (5742X) to the reference code (57280)
2. Evaluating the recommendation using IWPUT analysis

**COMPARING THE SURVEYED CODE (5742X) TO THE REFERENCE CODE (57280)**

The Panel compared the surveyed code (5742X) to the reference code (57280). There was agreement that the two codes were essentially the same procedure. The surveyed code required more physical effort than the reference code but the reference code has an easier post-op management time. The Panel concluded that these two factors balance each other out and result in the two codes being essentially the same procedure.

While it is generally the same procedure the Panel identified elements of laparoscopic surgery that justify a slightly higher RVW value for the surveyed code in comparison to the reference code.

- Laparoscopic surgery does not have the reduced intensity times during opening and closing, as do abdominal surgeries.
- Laparoscopic surgery requires the development of specialized skills
- Laparoscopic surgery requires the physician to view their surgical environment using cameras and other technology

**EVALUATING THE RECOMMENDATION USING IWPUR ANALYSIS**

The Panel then used IWPUR analysis to compare the two codes.

*Pre-Service Time*

Before conducting IWPUR analysis there was discussion on the issue of pre-service time. The panel agreed that laparoscopic surgery takes additional pre-service time because the equipment needs to be prepared and the patient has to be positioned. While the survey resulted in a median of 85 minutes of pre-service time, the Panel agreed to reduce this time to 60 minutes in order to make the data fit more appropriately with other data in the RUC database.

After agreeing to reduce the pre-service time to 60 minutes, the Panel conducted IWPUR analysis.

*Surveyed Code – 5742X*

The panel tested the validity of 15.75 using the IWPUR analysis. **Applying the formula to the surveyed code resulted in an IWPUR of .06.** (CPT code values: 99231= .64; 99232= 1.06; 99233= 1.51; 99238=1.28; 99213= .67)

$$15.75 - \{.0224(60\text{min}) + .0224(30 \text{ min}) + 1.06 + 1.06 + 1.28 + .67 + .67\} / 120 \text{ min} = \underline{\underline{.06 \text{ IWPUR}}}$$

*Reference Code - 57280*

The Panel then tested the IWPUR of the reference code and compared it to the surveyed code.

$$15.04 - \{.0224(60\text{min}) + .0224(45 \text{ min}) + .64 + .64 1.06 + 1.51 + 1.28 + .67 + .67\} / 115 \text{ min} = \underline{\underline{.05 \text{ IWPUR}}}$$

**The panel concluded that .06 IWPUR for the surveyed code, slightly higher than the reference code, was an appropriate value for this level of service.**

The panel unanimously supported the recommendation of 15.75 RVW for CPT code 5742X.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

No

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

The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain) \_\_\_\_\_

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

N/A

**FREQUENCY INFORMATION**

How was this service previously reported? 49329, Unlisted Laparoscopy procedure, abdomen, peritoneum and omentum (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty: Gynecologic Laparoscopists     Commonly     Sometimes     Rarely

Specialty: Gynecologists     Commonly     Sometimes     Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gynecologic Laparoscopists    Frequency 600-700

Specialty Gynecologists    Frequency rarely performed

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

Specialty Gynecologic Laparoscopists    Frequency \_\_\_\_\_

Specialty Gynecologists    Frequency \_\_\_\_\_

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

	A	B	CACOG	D
1			FAMILY 6742X	
2			CPT Code :57425	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Laparoscopy, surgical, colpopexy (suspension of vaginal apex)	
4	LOCATION		In Office	Out Office
5	GLOBAL PERIOD			90
6	TOTAL CLINICAL LABOR TIME		0.0	144.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		0.0	60.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		0.0	12.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		0.0	72.0
10	PRE-SERVICE			
11	Start: Following visit when decision for surgery or procedure made			
12	Complete pre-service diagnostic & referral forms			5
13	Coordinate pre-surgery services			20
14	Schedule space and equipment in facility			8
15	Office visit before surgery/procedure Review test and exam results			
16	Provide pre-service education/obtain consent			20
17	Follow-up phone calls & prescriptions			7
18	Other Clinical Activity (please specify)			
19	End:When patient enters office/facility for surgery/procedure			
20	SERVICE PERIOD			
21	Start: When patient enters office/facility for surgery/procedure			
22	Pre-service services			
23	Review charts			
24	Greet patient and provide gowning			
25	Obtain vital signs			
26	Provide pre-service education/obtain consent			
27	Prepare room, equipment, supplies			
28	Prepare and position patient/ monitor patient/ set up IV			
29	Sedate/apply anesthesia			
30	Intra-service			
31	Assist physician in performing procedure			
32	Post-Service			
33	Monitor pt following service/check tubes, monitors, drains			
34	Clean room/equipment by physician staff			
35	Complete diagnostic forms, lab & X-ray requisitions			
36	Review/read X-ray, lab, and pathology reports			
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			
38	Coordination of Care			
39	Discharge day management 99238 --12 minutes 99239 --15 minutes			12
40	Other Clinical Activity (please specify)			
41	End: Patient leaves office			
42	POST-SERVICE Period			
43	Start: Patient leaves office/facility			
44	Conduct phone calls/call in prescriptions			
45	Office visits Greet patient, escort to room, provide gowning, interval history & vital signs and chart, assemble previous test reports/results, assist physician during exam, assist with dressings, wound care, suture removal, prepare dx test, prescription forms, post service education, instruction, counseling, clean room/equip, check supplies, coordinate home or outpatient care			
46	List Number and Level of Office Visits			
47	99211 16 minutes	16		
48	99212 27 minutes	27		
49	99213 36 minutes	36		72
50	99214 53 minutes	53		
51	99215 63 minutes	63		
52	Other			
53				
54	Total Office Visit Time		0	72
55	Other Activity (please specify)			
56	End: with last office visit before end of global period			

	A	B	CACOG D	
2			CPT Code -57425	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Laparoscopy, surgical, colpopexy (suspension, of vaginal apex)	
4	LOCATION		In Office	Out Office
57	<b>MEDICAL SUPPLIES</b>			
58	drape sheet	1106		1
59	Minimum supply package			2
60	pelvic exam package			2
61	suture removal kit			1
62				
63				
64				
65	<b>Equipment</b>			
66	power table	E11003		72
67	fiberoptic exam light	E11006		72
68				
69				
70				
71				

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Intrauterine Fetal Surgical Procedures**

The RUC considered a request that this family of codes be carrier priced for 2004 since the presenters were unable to obtain sufficient survey data. The presenters will make recommendations to the RUC at the September, 2003 RUC meeting.

**The RUC recommends that codes 59070, 59072, 59074, 59076, and 59897 be carrier priced for 2004.**

CPT Code (•New)	Track ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
•59070	DD4	Transabdominal amnioinfusion, including ultrasound guidance	000	Carrier Price
•59072	DD2	Fetal umbilical cord occlusion, including ultrasound guidance	000	Carrier Price
•59074	DD3	Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance	000	Carrier Price
•59076	DD1	Fetal shunt placement, including ultrasound guidance (For unlisted fetal invasive procedure, use 59897)	000	Carrier Price
•59897	DD5	Unlisted fetal invasive procedure, including ultrasound guidance	YYY	Carrier Price

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Limited Temporal Lobe Resection and Lobectomy without Corticography**

The CPT Editorial Panel created the limited temporal resection and lobectomy without corticography codes to describe the recent developments which have allowed lobectomies to not involve electrocorticography. In addition, new codes and revisions to existing codes were developed to describe the latest techniques which have been developed for limited temporal lobe resection, functional hemispherectomy, and multiple subpial transactions.

61537

The RUC examined code 61537 *Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring; for lobectomy, temporal lobe, without electrocorticography during surgery*. It was determined by the RUC after reviewing reference code 61538 *Craniotomy with elevation of bone flap; for lobectomy, with electrocorticography during surgery, temporal lobe* (RVU = 26.81) that the intra-service time of the new code (intra-service time = 240 minutes) is higher than the intra-service time of the reference code (intra-service time 210 minutes). In addition, the intra-service period of the new code was deemed more intense than the reference code. This time and intensity difference between these two codes was reflected within the specialty society's survey which had a median RVW of 27.66. However, the RUC agreed with the specialty society that the 25<sup>th</sup> percentile RVW for 61537 is appropriate as it maintains the relativity to the reference code 61538. **Therefore, the RUC recommends a work relative value of 25.00 for 61537.**

61540

The RUC examined code 61540 *Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring; for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery*. It was determined by the RUC after reviewing reference code 61539 *Craniotomy with elevation of bone flap; for lobectomy with electrocorticography during surgery, other than temporal lobe, partial or total* (RVU = 32.08) that the intra-service time of the new code (intra-service time = 300 minutes) is similar to the intra-service time of the reference code (intra-service time = 297 minutes). , the RUC agreed with the specialty society's survey median, 30.00 RVW as it correctly places the work value for 61540 between 61537 and 61539. The RUC noted that the IWPUT for 61537 and 61540 is also similar. **The RUC recommends a work relative value of 30.00 for 61540.**

### 61566

The RUC examined code 61566 *Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy*.

Amygdalohippocampectomy is a fairly new procedure which is very low volume and is only performed at certain epilepsy centers.

Although the procedure is performed through a similar craniotomy, amygdalohippocampectomy involves a microsurgical approach and dissection of these tissues without injuring the lateral temporal lobe. Amygdalohippocampectomy is a painstaking procedure which takes roughly two more hours than an amputation. Amygdalohippocampectomy is generally performed without electrocorticography since it is an anatomical resection. It was determined by the RUC after reviewing the intra-service time of the surveyed code (intra-service time = 240 minutes) that it is significantly more when compared to the intra-service time of the reference code 61538 *Craniotomy with elevation of bone flap; for lobectomy with electrocorticography during surgery, temporal lobe* (intra-service time = 210) (work RVU = 26.81). In addition, 61566 is deemed more intense and requires more mental effort and judgment than the reference code. Therefore, the RUC agrees with the specialty society that the increased time and intensity required to perform this procedure support the specialty society's median value of their survey (RVU = 31.00). **The RUC recommends a work relative value of 31.00 for 61566.**

### 61567

The RUC examined code 61567 *Craniotomy with elevation of bone flap; for multiple subpial transections, with electrocorticography during surgery*. This procedure involves a large hemispherical craniotomy and extensive intraoperative electrocorticography. In comparison, the reference code 61536 *Craniotomy with elevation of bone flap; for excision of cerebral epileptogenic focus, with electrocorticography during surgery (includes removal of electrode array)* (RVU = 35.52) involves a similar craniotomy and resection of an epileptogenic focus defined by electrocorticography. 61567 involves dissection to disconnect the horizontal cortical connections and to preserve the vertical axons, thus limiting seizure spread without removing this "eloquent" brain. This must be performed without interrupting the blood supply to that cortex. As such, this is a more intense procedure which carries a higher risk of serious complications as compared to the reference code. Although the intra-service time of 61567 (intra-service time = 280 minutes) is less than the reference service code (intra-service time = 298), the intensity, as reflected also in its IWPOT of 0.091, is in keeping with the intensity of other high risk intracranial procedures. Therefore the RUC agreed with the specialty society that the median survey RVU of 35.50 is recommended for 61567. This recommendation is similar to the work value of the reference code and fairly balances the higher intensity intra-service component with the lower intra-service time. **The RUC recommends a work relative value of 35.50 for 61567.**

Practice Expense:

The practice expense inputs for 61537-61567 follow the PEAC accepted neurosurgery craniotomy procedure packages and the RUC approved “standard” neurosurgery post-operative incision care kit. **The practice expense recommendations presented by the specialty society were accepted by the RUC.**

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●61537	N1	Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring; for lobectomy, temporal lobe, without electrocorticography during surgery	090	25.00
▲61538		for lobectomy, <u>temporal lobe</u> , with electrocorticography during surgery; <del>temporal lobe</del>	090	26.81 (No Change)
▲61539		for lobectomy, <u>other than temporal lobe, partial or total</u> , with electrocorticography during surgery, <del>other than temporal lobe, partial or total</del>	090	32.08 (No Change)
●61540	N2	for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery	090	30.00
▲61543		for partial or subtotal ( <u>functional</u> ) hemispherectomy		29.22 (No Change)
●61566	N3	Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy	090	31.00
●61567	N4	for multiple subpial transections, with electrocorticography during surgery	090	35.50

CPT Code: 61537

Tracking No: N1 Global: 090

Recommended RVW: 25.00  
25<sup>th</sup> percentile

**Descriptor:** Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, without electrocorticography during surgery

---

**SURVEY Vignette (Typical Patient)**

A 24-year-old woman presents with chronic, intractable complex partial seizures. She previously had undergone an extensive evaluation with long-term video EEG analysis of her seizures that had clearly identified the seizure focus in the right temporal lobe. At operation, her right temporal lobe, including the amygdala and anterior hippocampus, are removed (without intraoperative electrocorticography). Postoperative hospital care and office visits are conducted as necessary through the 90-day global.

---

**Description of Service**

Pre-service, after decision to operate and prior to the day of surgery

Plan and review the surgical approach which will allow entrance to the skull to remove the portion of temporal lobe, hippocampus and amygdala responsible for the patient's seizure; Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family; Obtain informed consent; Confirm that all specialized equipment will be available in the operating room; Dictate a letter to the referring physician and call the referring physician to discuss the proposed surgery

Pre-service, day of surgery

Greet the patient in the pre-operative holding area and answers any final questions from the family; Review pre-operative lab work-up; Write pre-operative orders for peri-operative medications; Review planned incisions and procedure; Locate, review, and place MRI and films on the view box in the operating room; Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite; Accompany patient to operating room; Change into scrub clothes; Review length and type of anesthesia with anesthesiologist; Monitor initial patient positioning for induction of general anesthesia; After general anesthesia is induced, the patient's scalp is shaved at the site of the incision.; Apply a Mayfield pin head holder to the patient's head; Position the patient with the right shoulder elevated and the patient's head turned to the left -positioning of the patient is completed so that there is not any unusual pressure on neurovascular structures; Prep the patient; Scrub and gown; Mark the incisions and supervise draping of the patient

Intra-service

An incision is made and hemostasis achieved with retraction and electrocautery. Burr holes are made at the periphery of the exposure and connected using the craniotome. The bone flap is elevated and the dura is exposed. The dura is opened with sharp dissection and the dural edges are retracted. The neurosurgeon measures the temporal lobe from its anterior extent and determines where the cortical incisions will be made. After cortical incisions are made, a dissection is made deep to the cortex with the ultrasonic aspirator. This dissection is made in the coronal plane approximately 4 cm from the anterior tip of the temporal lobe until the temporal horn of the lateral ventricle and the hippocampus are identified. The dissection then spares these medial structures for the time being. When the pia of the medial cortex is encountered, a sub-pial dissection is made. The pia is then coagulated with bipolar coagulation and opened with sharp dissection. The anterior and lateral portion of the temporal lobe is then removed, leaving the mesial temporal structures. A very careful and delicate dissection is then made of the hippocampus, amygdala and uncus. Great care is taken to identify, coagulate and divide perforating arteries from the posterior cerebral artery to the hippocampus without damaging the posterior cerebral artery. Great care is also taken to preserve the anterior choroidal artery and the pia-arachnoid overlying the ambient cistern which contains the internal carotid artery, the posterior cerebral artery, the third, fourth, fifth and sixth cranial nerves, the basilar vein of Rosenthal, the optic tract, the lateral geniculate, and the brainstem. Hemostasis is achieved. The dura is sutured so that it is watertight. The bone flap is replaced and secured to the surrounding bone with titanium plates and screws. The temporalis muscle is sutured together and then the galea and skin are closed.

Post-service, day of surgery

The patient's head is removed from three-point fixation and sterile dressings are applied; Write an OP note in the patient's record; Monitor for abnormal neurological findings ; Sign OR forms, including pre- and postoperative diagnosis, operations performed; Discuss procedure outcome with family; Dictate postop report; Discuss procedure outcome with referring physician; Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company; Call referring physician to discuss the surgery; Order and review films and a CT of the head to ensure that there is no postoperative hemorrhage and that there are no new, unexpected findings; Order and review blood and serum analysis and adjust anti-seizure medication as necessary; Consult with epilepsy team in intensive care unit

Post-service, hospital, after day of surgery, through discharge

Write orders to transfer patient to acute care floor, when appropriate; Write orders for post-op labs, films, medications, diet, and patient activity; Examine patient daily, check wounds and patient progress; Review nursing/other staff patient chart notes; Chart patient progress notes; Discuss patient progress with referring physician (verbal and written); Answer patient/family questions, nursing/other staff questions (verbal and written), insurance staff questions; At discharge, review post-discharge wound care and activity limitations with patient/family; Answer patient/family questions, nursing/other staff questions; Write orders for post-discharge labs, films, and medications; Chart patient discharge notes

Post-service, office

Take telephone calls from patient/family regarding questions about persistent headache; Write orders for medications and follow-up CT; Review post-discharge CT; Examine patient, check patient progress; Remove sutures, when appropriate; Dictate patient progress notes for medical chart; Answer mother/family questions, insurance staff questions; Discuss patient progress with referring physician and epileptologist (verbal and written)

**SURVEY DATA**

<b>Presenter(s):</b>	Jeffrey Cozzens, MD						
<b>Specialty(s):</b>	American Association of Neurological Surgeons/Congress of Neurological Surgeons						
<b>CPT Code:</b>	61537						
<b>Sample Size:</b>	40	<b>Resp n:</b>	20	<b>Resp %:</b>	50%		
<b>Sample Type:</b>	Random (response rate is low because this is a rarely performed procedure)						
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>	
<b>Survey RVW:</b>		24.00	25.00	27.66	30.00	35.00	
<b>Pre-Service Evaluation Time:</b>				60			
<b>Pre-Service Positioning Time:</b>				20			
<b>Pre-Service Scrub, Dress, Wait Time:</b>				20			
<b>Intra-Service Time:</b>		200	240	240	300	375	
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>					
<b>Immed. Post-time:</b>	30	LOS = 5					
<b>Critical Care time/visit(s):</b>	0						
<b>Other Hospital time/visit(s):</b>	87					99232 x 1	99231 x 3
<b>Discharge Day Mgmt:</b>	36					99236	
<b>Office time/visit(s):</b>	61					99213 x 2	99212 x 1

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
61537	Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, without electrocorticography during surgery	Recom'd 25.00	90
61538	Craniotomy with elevation of bone flap; for lobectomy with electrocorticography during surgery, temporal lobe	26.81	90

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

	Svy CPT 61537	Ref CPT 61538 1 <sup>st</sup> SYR
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response Count	20	3
Pre-service	100	135
Intra-service	240	210
Same Day Immediate Post-service	30	35
Critical care	0	0
Other hospital visit	87	106
Discharge day management	36	36
Office visit	61	76
<b>TOTAL TIME</b>	<b>554</b>	<b>598</b>

**INTENSITY/COMPLEXITY MEASURES (mean)**

Survey Response Count	11	11
-----------------------	----	----

**TIME SEGMENTS**

Pre-service	4.71	4.29
Intra-service	4.86	4.29
Post-service	3.94	3.71

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	4.50	4.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	4.57
Urgency of medical decision making	3.75	3.43

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	4.57	4.00
Physical effort required	4.29	3.86

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	4.86	4.29
Outcome depends on the skill and judgment of physician	4.57	4.29
Estimated risk of malpractice suit with poor outcome	4.29	3.86

**ADDITIONAL RATIONALE**

The consensus committee reviewing the survey data are concerned that the time data for 61537 from 20 "specialty" neurosurgeons is compared to the time data for 61538 which is based on a response rate of "3." We also note, based on the advice of surgeons who perform both 61537 and 61538, that the intra-operative time of 210 min. for 61538 from 3 "general" neurosurgeons (out of 275 surveys sent) is understated, and that the previous intraoperative time from the Harvard study for 61538 of 285 minutes is probably more accurate. Although the AANS/CNS consensus committee believes that the median RVW is an accurate representation for the physician work of 61537, we are recommending the survey 25<sup>th</sup> percentile RVW of 25.00 to maintain relativity to the reference code 61538.

**IWPUT Analysis**

ROW / COLUMN      A      B      C      D      E      F

1	<b>61537 (25<sup>th</sup> pctl)</b>	<b>61537</b>	<b>Svy RVW:</b>	<b>25.00</b>	<b>61538</b>	<b>MFS RVW:</b>	<b>26.81</b>
2	<b>and 61538</b>	<b>Svy Data</b>	<b>RUC Std.</b>	<b>RVW</b>	<b>Svy Data</b>	<b>RUC Std.</b>	<b>RVW</b>
3	<b>Pre-service:</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>
4	Pre: eval & posit	80	0.0224	1.79	115	0.0224	2.58
5	Pre: scrub,dress,wait	20	0.0081	0.16	20	0.0081	0.16
6	<b>Pre-service total</b>			<b>1.95</b>			<b>2.74</b>
7	<b>Post-service:</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>
8	Immediate post	30	0.0224	0.67	35	0.0224	0.78
9	<b>Subsequent visits:</b>	<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>	<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>
10	ICU 99291		4.00			4.00	
11	99233		1.51			1.51	
12	99232	1	1.06	1.06	1	1.06	1.06
13	99231	3	0.64	1.92	4	0.64	2.56
14	Discharge 99238	1	1.28	1.28	1	1.28	1.28
15	Discharge 99239		1.75			1.75	
16	99214		1.08		2	1.08	2.16
17	99213	2	0.65	1.30		0.65	
18	99212	1	0.43	0.43		0.43	
19	99211		0.17			0.17	
20	<b>Post-service total</b>			<b>6.66</b>			<b>7.84</b>
21	<b>Intra-service:</b>	<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>	<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>
22	<b>Intra total</b>	<b>240</b>	<b>0.068</b>	<b>16.38</b>	<b>210</b>	<b>0.077</b>	<b>16.23</b>

**Services Reported with Multiple CPT Codes**

1. Is this new/revised code typically reported on the same date with other CPT codes? Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

<b>X</b>	The surveyed code is <del>an add-on code</del> or a <b>base code</b> expected to <del>that may</del> be reported with an add-on code.
----------	---

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. I

When microdissection utilizing the operating microscope is necessary, code 69990 would be reported as an add-on code.

CPT	Glob	'03 RVW	total time
61537	090	25.00	554
69990	ZZZ	3.47	n/a*
<b>Total</b>		<b>28.47</b>	

\*69990 *Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)* A specific intra-operative time is not associated with this code. Use of the operating microscope will add time and intensity to any operation, when employed.

**FREQUENCY INFORMATION****How was this service previously reported?**

The service may have been coded using:

61538-52 Craniotomy with elevation of bone flap; for lobectomy with electrocorticography during surgery, temporal lobe

64999 Unlisted procedure, nervous system

**How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Neurosurgery                      ~~Commonly~~—Sometimes      Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Neurosurgery                      Frequency: Less than 200

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

Specialty: Neurosurgery                      Frequency: Less than 50

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

---

CPT Code: 61540

Tracking No:N2

Global: 090

Recommended RVW: 30.00

**Descriptor:** Craniotomy with elevation of bone flap; for lobectomy, other than temporal lobe, partial or total; without electrocorticography during surgery

---

**SURVEY Vignette (Typical Patient)**

A 30-year-old woman presents with chronic, intractable complex partial seizures. A preoperative MRI demonstrated a glial scar in the frontal lobe. Prolonged videomonitoring confirmed that the seizures arise from that lobe. At operation, her right frontal lobe is removed (without intraoperative electrocorticography). Postoperative hospital care and office visits are conducted as necessary through the 90-day global.

---

**Description of Service**

Pre-service, after decision to operate and prior to the day of surgery

Plan and review the surgical approach which will allow entrance to the skull to remove the portion of frontal lobe responsible for the patient's seizure; Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family; Obtain informed consent; Confirm that all specialized equipment will be available in the operating room; Dictate a letter to the referring physician and call the referring physician to discuss the proposed surgery

Pre-service, day of surgery

Greet the patient in the pre-operative holding area and answers any final questions from the family; Review pre-operative lab work-up; Write pre-operative orders for peri-operative medications; Review planned incisions and procedure; Locate, review, and place MRI and films on the view box in the operating room; Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite; Accompany patient to operating room; Change into scrub clothes; Review length and type of anesthesia with anesthesiologist; Monitor initial patient positioning for induction of general anesthesia; After general anesthesia is induced, the patient's scalp is shaved at the site of the incision; Apply a Mayfield pin head holder to the patient's head; Position the patient with the right shoulder elevated and the patient's head turned to the left -positioning of the patient is completed so that there is not any unusual pressure on neurovascular structures; Prep the patient; Scrub and gown; Mark the incisions and supervise draping of the patient

*Intra-service*

The neurosurgeon then makes an incision and achieves hemostasis with retraction and electrocautery. Burr holes are made at the periphery of the exposure and connected using the craniotome. The bone flap is elevated and the dura is exposed. The dura is opened with sharp dissection and the dural edges are retracted. The neurosurgeon measures the frontal lobe from its anterior extent and determines where he will make the cortical incisions. Cortical incisions are then made. A dissection is made deep to the cortex with the ultrasonic aspirator. This dissection is made in the coronal plane approximately 3 cm from the anterior tip of the frontal lobe. When the pia of the medial cortex is encountered, a sub-pial dissection is made. The pia is then coagulated with bipolar coagulation and opened with sharp dissection. The anterior cerebral arteries are identified and protected during the dissection. The anterior portion of the frontal lobe is then removed. Hemostasis is achieved. The dura is sutured so that it is watertight. The bone flap is replaced and secured to the surrounding bone with titanium plates and screws. The galea and skin are closed.

Post-service, day of surgery

The patient's head is removed from three-point fixation and sterile dressings are applied; Write an OP note in the patient's record; Monitor for abnormal neurological findings ; Sign OR forms, including pre- and postoperative diagnosis, operations performed; Discuss procedure outcome with family; Dictate postop report; Discuss procedure outcome with referring physician; Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company; Call referring physician to discuss the surgery; Order and review films and a CT of the head to ensure that there is no postoperative hemorrhage and that there are no new, unexpected findings; Order and review blood and serum analysis and adjust anti-seizure medication as necessary; Consult with epilepsy team in intensive care unit

Post-service, hospital, after day of surgery, through discharge

Write orders to transfer patient to acute care floor, when appropriate; Write orders for post-op labs, films, medications, diet, and patient activity; Examine patient daily, check wounds and patient progress ; Review nursing/other staff patient chart notes; Chart patient progress notes; Discuss patient progress with referring physician (verbal and written); Answer patient/family questions, nursing/other staff questions (verbal and written), insurance staff questions; At discharge, review post-discharge wound care and activity limitations with patient/family; Answer patient/family questions, nursing/other staff questions; Write orders for post-discharge labs, films, and medications; Chart patient discharge notes

Post-service, office

Take telephone calls from patient/family regarding questions about persistent headache; Write orders for medications and follow-up CT; Review post-discharge CT; Examine patient, check patient progress ;Remove sutures, when appropriate; Dictate patient progress notes for medical chart; Answer mother/family questions, insurance staff questions; Discuss patient progress with referring physician and epileptologist (verbal and written)

**SURVEY DATA**

<b>Presenter(s):</b>	Jeffrey Cozzens, MD				
<b>Specialty(s):</b>	American Association of Neurological Surgeons/Congress of Neurological Surgeons				
<b>CPT Code:</b>	61540				
<b>Sample Size:</b>	40	<b>Resp n:</b>	20	<b>Resp %:</b>	50%
<b>Sample Type:</b>	Random (response rate is low because this is a rarely performed procedure)				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	24.00	28.50	30.00	31.00	40.00
<b>Pre-Service Evaluation Time:</b>			75		
<b>Pre-Service Positioning Time:</b>			20		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			20		
<b>Intra-Service Time:</b>	210	240	300	300	435
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	40				LOS = 5
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	87	99232 x 1 99231 x 3			
<b>Discharge Day Mgmt:</b>	36	99236			
<b>Office time/visit(s):</b>	61	99213 x 2 99212 x 1			

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
61540	<i>Craniotomy with elevation of bone flap, for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery</i>	<i>Recom'd 30.00</i>	90
61539	Craniotomy with elevation of bone flap; for lobectomy with electrocorticography during surgery, other than temporal lobe, partial or total	32.08	90

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

	Svy CPT 61540	Ref CPT 61539 HVD
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response Count	20	--
Pre-service	115	48
Intra-service	300	297
Same Day Immediate Post-service	40	65
Critical care	0	0
Other hospital visit	87	165.8
Discharge day management	36	
Office visit	61	52.5
<b>TOTAL TIME</b>	639	628

**INTENSITY/COMPLEXITY MEASURES (mean)**

Survey Response Count	9	9
-----------------------	---	---

**TIME SEGMENTS**

Pre-service	4.43	4.29
Intra-service	4.57	4.00
Post-service	3.14	3.00

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.86	4.71
Urgency of medical decision making	2.29	2.29

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	4.43	4.29
Physical effort required	3.86	3.71

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	3.57	3.57
Outcome depends on the skill and judgment of physician	4.57	4.57
Estimated risk of malpractice suit with poor outcome	4.43	4.43

**ADDITIONAL RATIONALE**

**The survey median RVW of 30.00 for 61540 is recommended.** This value correctly places X2 between X1 and 61539. The time, intensity/complexity measures, and iwput analysis support this recommendation.

**IWPUT Analysis**

ROW / COLUMN	A	B	C	D	E	F	
1	<b>61540 and 61539</b>	<b>61540 Svy Data</b>	<b>Svy RVW: RUC Std.</b>	<b>30.00 RVW</b>	<b>61539 Svy Data</b>	<b>MFS RVW: RUC Std.</b>	<b>32.08 RVW</b>
3	<b>Pre-service:</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>
4	Pre: eval & posit	95	0.0224	2.13	28	0.0224	0.63
5	Pre: scrub,dress,wait	20	0.0081	0.16	20	0.0081	0.16
6	<b>Pre-service total</b>			<b>2.29</b>			<b>0.79</b>
7	<b>Post-service:</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>
8	Immediate post	40	0.0224	0.90	65	0.0224	1.46
9	<b>Subsequent visits:</b>	<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>	<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>
10	ICU 99291		4.00			4.00	
11	99233		1.51			1.51	
12	99232	1	1.06	1.06		1.06	
13	99231	3	0.64	1.92	12	0.64	7.68
14	Discharge 99238	1	1.28	1.28	1	1.28	1.28
15	Discharge 99239		1.75			1.75	
16	99214		1.08			1.08	
17	99213	2	0.65	1.30	2.5	0.65	1.63
18	99212	1	0.43	0.43		0.43	
19	99211		0.17			0.17	
20	<b>Post-service total</b>			<b>6.89</b>			<b>12.04</b>
21	<b>Intra-service:</b>	<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>	<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>
22	<b>Intra total</b>	<b>300</b>	<b>0.069</b>	<b>20.82</b>	<b>297</b>	<b>0.065</b>	<b>19.25</b>

**Services Reported with Multiple CPT Codes**

- Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions:

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

<input checked="" type="checkbox"/>	The surveyed code is an <del>add-on code</del> or a <b>base code</b> expected to <del>that may be</del> reported with an add-on code.
<input type="checkbox"/>	Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
<input type="checkbox"/>	Multiple codes allow flexibility to describe exactly what components the procedure included.
<input type="checkbox"/>	Multiple codes are used to maintain consistency with similar codes.
<input type="checkbox"/>	Historical precedents.
<input type="checkbox"/>	Other reason (please explain):

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

When microdissection utilizing the operating microscope is necessary, code 69990 would be reported as an add-on code.

CPT	Glob	'03 RVW	total time
61540	090	25.00	554
69990	ZZZ	3.47	n/a*
<b>Total</b>		<b>28.47</b>	

\*69990 *Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)* A specific intra-operative time is not associated with this code. Use of the operating microscope will add time and intensity to any operation, when employed.

## FREQUENCY INFORMATION

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

The service may have been coded using:

61539-52 Craniotomy with elevation of bone flap; for lobectomy with electrocorticography during surgery, other than temporal lobe, partial or total

64999 Unlisted procedure, nervous system

**How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Neurosurgery                      ~~Commonly~~—Sometimes                      Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Neurosurgery                      Frequency: Less than 200

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

Specialty: Neurosurgery                      Frequency: Less than 50

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

CPT Code: 61566

Tracking No: N3

Global: 090

Recommended RVW: 31.00

**Descriptor:** Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy

---

**SURVEY Vignette (Typical Patient)**

A 30-year-old woman presents with chronic, intractable complex partial seizures. She previously had undergone an extensive evaluation with long-term video EEG analysis of her seizures that had clearly identified the seizure focus in the right mesial temporal structures including the amygdala and hippocampus. A preoperative MRI demonstrated hippocampal volume loss consistent with mesial temporal sclerosis. At operation, she undergoes surgery for removal of her right amygdala and anterior hippocampus. Postoperative hospital care and office visits are conducted as necessary through the 90-day global.

---

**Description of Service**

Pre-service, after decision to operate and prior to the day of surgery

Plan and review the surgical approach which will allow entrance to the skull to remove the portion of temporal lobe, hippocampus and amygdala responsible for the patient's seizure; Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family; Obtain informed consent; Confirm that all specialized equipment will be available in the operating room; Dictate a letter to the referring physician and call the referring physician to discuss the proposed surgery

Pre-service, day of surgery

Greet the patient in the pre-operative holding area and answers any final questions from the family; Review pre-operative lab work-up; Write pre-operative orders for peri-operative medications; Review planned incisions and procedure; Locate, review, and place MRI and films on the view box in the operating room; Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite; Accompany patient to operating room; Change into scrub clothes; Review length and type of anesthesia with anesthesiologist; Monitor initial patient positioning for induction of general anesthesia; After general anesthesia is induced, the patient's scalp is shaved at the site of the incision.; Apply a Mayfield pin head holder to the patient's head; Position the patient with the right shoulder elevated and the patient's head turned to the left -positioning of the patient is completed so that there is not any unusual pressure on neurovascular structures; Prep the patient; Scrub and gown; Mark the incisions and supervise draping of the patient

*Intra-service*

The neurosurgeon then makes an incision and achieves hemostasis with retraction and electrocautery. Burr holes are made at the periphery of the exposure and connected using the craniotome. The bone flap is elevated and the dura is exposed. The dura is opened with sharp dissection and the dural edges are retracted. The neurosurgeon measures the temporal lobe from its anterior extent and determines where he will make the cortical incisions. Cortical incisions are then made. A dissection is made deep to the cortex with the ultrasonic aspirator. This dissection is made until the temporal horn of the lateral ventricle and the hippocampus are identified. A very careful and delicate dissection is then made of the hippocampus and amygdala. Great care is taken to identify, coagulate and divide perforating arteries from the posterior cerebral artery to the hippocampus without damaging the posterior cerebral artery. Great care is also taken to preserve the anterior choroidal artery and the pia-arachnoid overlying the ambient cistern which contains the internal carotid artery, the posterior cerebral artery, the third, fourth, fifth and sixth cranial nerves, the basilar vein of Rosenthal, the optic tract, the lateral geniculate, and the brainstem. Hemostasis is achieved. The dura is sutured so that it is watertight. The bone flap is replaced and secured to the surrounding bone with titanium plates and screws. The temporalis muscle is sutured together and then the galea and skin are closed.

Post-service, day of surgery

The patient's head is removed from three-point fixation and sterile dressings are applied; Write an OP note in the patient's record; Monitor for abnormal neurological findings; Sign OR forms, including pre- and postoperative diagnosis, operations performed; Discuss procedure outcome with family; Dictate postop report; Discuss procedure outcome with referring physician; Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company; Call referring physician to discuss the surgery; Order and review films and a CT of the head to ensure that there is no postoperative hemorrhage and that there are no new, unexpected findings; Order and review blood and serum analysis and adjust anti-seizure medication as necessary; Consult with epilepsy team in intensive care unit

Post-service, hospital, after day of surgery, through discharge

Write orders to transfer patient to acute care floor, when appropriate; Write orders for post-op labs, films, medications, diet, and patient activity; Examine patient daily, check wounds and patient progress; Review nursing/other staff patient chart notes; Chart patient progress notes; Discuss patient progress with referring physician (verbal and written); Answer patient/family questions, nursing/other staff questions (verbal and written), insurance staff questions; At discharge, review post-discharge wound care and activity limitations with patient/family; Answer patient/family questions, nursing/other staff questions; Write orders for post-discharge labs, films, and medications; Chart patient discharge notes

Post-service, office

Take telephone calls from patient/family regarding questions about persistent headache; Write orders for medications and follow-up CT; Review post-discharge CT; Examine patient, check patient progress; Remove sutures, when appropriate; Dictate patient progress notes for medical chart; Answer mother/family questions, insurance staff questions; Discuss patient progress with referring physician and epileptologist (verbal and written)

**SURVEY DATA**

<b>Presenter(s):</b>	Jeffrey Cozzens, MD					
<b>Specialty(s):</b>	American Association of Neurological Surgeons/Congress of Neurological Surgeons					
<b>CPT Code:</b>	61566					
<b>Sample Size:</b>	40	<b>Resp n:</b>	20	<b>Resp %:</b>	50%	
<b>Sample Type:</b>	Random (response rate is low because this is a rarely performed procedure)					
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		23.50	28.00	31.00	36.50	45.00
<b>Pre-Service Evaluation Time:</b>				75		
<b>Pre-Service Positioning Time:</b>				20		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				20		
<b>Intra-Service Time:</b>		210	240	240	285	375
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	35	LOS = 6				
<b>Critical Care time/visit(s):</b>	0					
<b>Other Hospital time/visit(s):</b>	106					99232 x 1 99231 x 4
<b>Discharge Day Mgmt:</b>	36					99236
<b>Office time/visit(s):</b>	61					99213 x 2 99212 x 1

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
61566	Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy	<i>Recom'd</i> 31.00	90
61538	Craniotomy with elevation of bone flap; for lobectomy with electrocorticography during surgery, temporal lobe	26.81	90

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

	Svy CPT 61566	Ref CPT 61538 1 <sup>st</sup> SYR
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response Count	20	3
Pre-service	115	135
Intra-service	240	210
Same Day Immediate Post-service	35	35
Critical care	0	0
Other hospital visit	106	106
Discharge day management	36	36
Office visit	61	76
<b>TOTAL TIME</b>	593	598
<b>INTENSITY/COMPLEXITY MEASURES (mean)</b>		
Survey Response Count	7	7
<b>TIME SEGMENTS</b>		
Pre-service	4.20	4.00
Intra-service	4.50	4.00
Post-service	3.00	2.80
<b>MENTAL EFFORT AND JUDGMENT</b>		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.80	4.50
Urgency of medical decision making	2.50	2.00
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>		
Technical skill required	4.80	4.50
Physical effort required	3.80	3.80
<b>PSYCHOLOGICAL STRESS</b>		
The risk of significant complications, morbidity and/or mortality	4.00	4.00
Outcome depends on the skill and judgment of physician	4.50	4.60
Estimated risk of malpractice suit with poor outcome	4.00	4.00

**ADDITIONAL RATIONALE****1. Discussion of time and complexity/intensity comparison**

The survey median RVW of 31.00 for 61566 is recommended.

New code 61566 is performed in individuals who have intractable seizures coming from either the amygdala, hippocampus or both. amygdalohippocampectomy is performed when the individual has significant function in the lateral temporal neocortex and one wishes to spare that functional tissue, rather than perform a temporal amputation. Amygdalohippocampectomy is a fairly new procedure which is very low volume and is only performed at certain epilepsy centers. Although the procedure is performed through a similar craniotomy, amygdalohippocampectomy involves a microsurgical approach and dissection of these tissues without injuring the lateral temporal lobe. Amygdalohippocampectomy is a painstaking procedure which takes roughly two

more hours than an amputation. Amygdalohippocampectomy is generally performed without electrocorticography since it is an anatomical resection. The procedure requires more time (240 vs 210 minutes) than the reference code and is more intense.

We would like to note that in this survey, 13 of 20 respondents chose more difficult reference codes than 61538 (response = 7), indicating that this procedure was more difficult and should be of greater value. These other reference codes included 61510, 61514, 61534, 61539, and 61536. Thus the intensity reflected in this survey, based on 7 of 20 respondents who used 61538 as a reference code, does not reflect the intensity of the majority of respondents. However, the intensity/complexity means could not be calculated for 6-7 other codes with a response rate of 1 or 2.

## 2. IWPUT Analysis

ROW / COLUMN	A	B	C	D	E	F	
1	<b>61566 and 61538</b>	<b>61566 Svy Data</b>	<b>Svy RVW: RUC Std.</b>	<b>31.00 RVW</b>	<b>61538 Svy Data</b>	<b>MFS RVW: RUC Std.</b>	<b>26.81 RVW</b>
2							
3	<b>Pre-service:</b>	<b>Time</b>	<b>Intensity (=time x ints'y)</b>	<b>Time</b>	<b>Intensity (=time x ints'y)</b>	<b>Time</b>	<b>Intensity (=time x ints'y)</b>
4	Pre: eval & posit	95	0.0224	2.13	115	0.0224	2.58
5	Pre: scrub,dress,wait	20	0.0081	0.16	20	0.0081	0.16
6	<b>Pre-service total</b>		<b>2.29</b>			<b>2.74</b>	
7	<b>Post-service:</b>	<b>Time</b>	<b>Intensity (=time x ints'y)</b>	<b>Time</b>	<b>Intensity (=time x ints'y)</b>	<b>Time</b>	<b>Intensity (=time x ints'y)</b>
8	Immediate post	35	0.0224	0.78	35	0.0224	0.78
9	<b>Subsequent visits:</b>	<b>Visit n</b>	<b>E/M RVW (=n x RVW)</b>	<b>Visit n</b>	<b>E/M RVW (=n x RVW)</b>	<b>Visit n</b>	<b>E/M RVW (=n x RVW)</b>
10	ICU 99291		4.00				4.00
11	99233		1.51				1.51
12	99232	1	1.06	1.06	1	1.06	1.06
13	99231	4	0.64	2.56	4	0.64	2.56
14	Discharge 99238	1	1.28	1.28	1	1.28	1.28
15	Discharge 99239		1.75				1.75
16	99214		1.08		2	1.08	2.16
17	99213	2	0.65	1.30		0.65	
18	99212	1	0.43	0.43		0.43	
19	99211		0.17			0.17	
20	<b>Post-service total</b>		<b>7.41</b>			<b>7.84</b>	
21	<b>Intra-service:</b>	<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>	<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>
22	<b>Intra total</b>	<b>240</b>	<b>0.089</b>	<b>21.30</b>	<b>210</b>	<b>0.077</b>	<b>16.23</b>

**Services Reported with Multiple CPT Codes**

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

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

<b>X</b>	The surveyed code is an <del>add-on code</del> or a <b>base code</b> expected to <del>that may</del> be reported with an add-on code.
----------	---

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes.

When microdissection utilizing the operating microscope is necessary, code 69990 would be reported as an add-on code.

CPT	Glob	'03 RVW	total time
61566	090	25.00	<b>554</b>
69990	ZZZ	3.47	n/a*
<b>Total</b>		<b>28.47</b>	

\*69990 *Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)* A specific intra-operative time is not associated with this code. Use of the operating microscope will add time and intensity to any operation, when employed.

**FREQUENCY INFORMATION**

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

The service may have been coded using:

- 61538-52 Craniotomy with elevation of bone flap; for lobectomy with electrocorticography during surgery, temporal lobe
- 64999 Unlisted procedure, nervous system

**How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Neurosurgery                      Commonly ~~—~~ Sometimes                      Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Neurosurgery                      Frequency: Less than 100

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

Specialty: Neurosurgery                      Frequency: Less than 25

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

CPT Code: 61567

Tracking No: N4

Global: 090

Recommended RVW: 35.50

**Descriptor:** Craniotomy with elevation of bone flap; for multiple subpial transections; with electrocorticography during surgery

---

**SURVEY Vignette (Typical Patient)**

A 12 year-old boy presents with chronic, intractable complex partial seizures. He previously has undergone an extensive evaluation with long-term video EEG analysis of his seizures. The seizure focus is suspected to be in the right frontal-central region including the motor cortex but further characterization of the seizure focus is indicated. At operation, he undergoes surgery for exposure of his right frontal-central cortex. Intra-operative electrocorticography is performed and a seizure focus is clearly identified. The patient undergoes multiple subpial transections of his motor cortex. Postoperative hospital care and office visits are conducted as necessary through the 90-day global.

---

**Description of Service**

Pre-service, after decision to operate and prior to the day of surgery

Plan and review the surgical approach which will allow entrance to the skull, to record the electrical activity of the brain, and to carefully remove the frontal lobe that is responsible for the patient's seizures; Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family; Obtain informed consent; Confirm that all specialized equipment will be available in the operating room, including the need for the electrocorticography electrodes and apparatus; Dictate a letter to the referring physician and call the referring physician to discuss the proposed surgery

Pre-service, day of surgery

Greet the patient in the pre-operative holding area and answers any final questions from the family; Review pre-operative lab work-up; Write pre-operative orders for peri-operative medications; Review planned incisions and procedure; Locate, review, and place MRI and films on the view box in the operating room; Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite; Accompany patient to operating room; Change into scrub clothes; Review length and type of anesthesia with anesthesiologist; Monitor initial patient positioning for induction of general anesthesia; After general anesthesia is induced, the patient's scalp is shaved at the site of the incision; Apply a Mayfield pin head holder to the patient's head; Position the patient with the right shoulder elevated and the patient's head turned to the left -positioning of the patient is completed so that there is not any unusual pressure on neurovascular structures; Prep the patient; Scrub and gown; Mark the incisions and supervise draping of the patient .

Intra-service

The neurosurgeon then makes an incision and achieves hemostasis with retraction and electrocautery. Burr holes are made at the periphery of the exposure and connected using the craniotome. The bone flap is elevated and the dura is exposed. The dura is opened with sharp dissection and the dural edges are retracted. The neurosurgeon selects the electrodes and prepares the electrode contacts so that they will not harm the cortex of the brain. The neurosurgeon then places the electrodes on the brain in a pattern that the neurosurgeon in consultation with the epileptologist (neurologist) has determined will derive the best information about the electrical activity of the brain. The neurosurgeon makes several careful measurements of the position of the electrodes in reference to the cortical anatomy. The neurosurgeon then takes a sterile pen and draws the position of each electrode on a line drawing of the right cerebral hemisphere. The neurosurgeon then hands the sterile electrical cable from the electrode holder to the EEG technician. While the electrical activity of the brain is being recorded, the neurosurgeon gently irrigates the cortex and electrode contacts. The neurologist tells the neurosurgeon that one electrode is not making good contact with the brain. The neurosurgeon repositions the electrode and the neurologist tells the neurosurgeon that the problem has been solved. The neurosurgeon waits while the neurologist collects sufficient recordings. He keeps the exposed cortex wet and weights down the recording grid to make better electrical contact with the cortex. The recording strips and grids are moved several times to check various sites. The neurosurgeon then confers with the neurologist about the results and their implications for tailoring the resection. After the electrocorticography has been completed, the neurologist and neurosurgeon confer and decide that multiple pial transections in a limited area of the motor cortex will be required to ensure that the seizure focus has isolated from the rest of the brain. Each electrode is then carefully removed from the brain and replaced with a small numbered sterile "ticket." The neurosurgeon pierces the cortex with a curved probe at a sulcus adjacent to the gyrus identified as the seizure focus, and then in a linear motion disconnects the grey matter under the pia of the gyrus. The probe is removed and the procedure is repeated at one centimeter intervals along the gyrus for the extent of the seizure focus. Hemostasis is achieved. The dura is sutured so that it is watertight. The bone flap is replaced and secured to the surrounding bone with titanium plates and

screws. The temporalis muscle is sutured together and then the galea and skin are closed.

Post-service, day of surgery

The patient's head is removed from three-point fixation and sterile dressings are applied; Write an OP note in the patient's record; Monitor for abnormal neurological findings; Sign OR forms, including pre- and postoperative diagnosis, operations performed; Discuss procedure outcome with family; Dictate postop report; Discuss procedure outcome with referring physician; Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company; Call referring physician to discuss the surgery; Order and review films and a CT of the head to ensure that there is no postoperative hemorrhage and that there are no new, unexpected findings; Order and review blood and serum analysis and adjust anti-seizure medication as necessary; Consult with epilepsy team in intensive care unit

Post-service, hospital, after day of surgery, through discharge

Write orders to transfer patient to acute care floor, when appropriate; Write orders for post-op labs, films, medications, diet, and patient activity; Examine patient daily, check wounds and patient progress; Review nursing/other staff patient chart notes; Chart patient progress notes; Discuss patient progress with referring physician (verbal and written); Answer patient/family questions, nursing/other staff questions (verbal and written), insurance staff questions; At discharge, review post-discharge wound care and activity limitations with patient/family; Answer patient/family questions, nursing/other staff questions; Write orders for post-discharge labs, films, and medications; Chart patient discharge notes

Post-service, office

Take telephone calls from patient/family regarding questions about persistent headache; Write orders for medications and follow-up CT; Review post-discharge CT; Examine patient, check patient progress; Remove sutures, when appropriate; Dictate patient progress notes for medical chart; Answer mother/family questions, insurance staff questions; Discuss patient progress with referring physician and epileptologist (verbal and written)

**SURVEY DATA**

<b>Presenter(s):</b>	Jeffrey Cozzens, MD					
<b>Specialty(s):</b>	American Association of Neurological Surgeons/Congress of Neurological Surgeons					
<b>CPT Code:</b>	61567					
<b>Sample Size:</b>	40	<b>Resp n:</b>	20	<b>Resp %:</b>	50%	
<b>Sample Type:</b>	Random (response rate is low because this is a rarely performed procedure)					
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		24.00	35.00	35.50	35.52	38.00
<b>Pre-Service Evaluation Time:</b>				80		
<b>Pre-Service Positioning Time:</b>				20		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				20		
<b>Intra-Service Time:</b>		240	270	280	300	420
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	45	LOS = 6				
<b>Critical Care time/visit(s):</b>	0					
<b>Other Hospital time/visit(s):</b>	106					99232 x 1 99231 x 4
<b>Discharge Day Mgmt:</b>	36					99236
<b>Office time/visit(s):</b>	76					99213 x 2 99212 x 2

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
61567	<i>Craniotomy with elevation of bone flap; for multiple subpial transections; with electrocorticography during surgery</i>	<i>Recom'd 35.50</i>	90
61536	Craniotomy with elevation of bone flap; for excision of cerebral epileptogenic focus, with electrocorticography during surgery (includes removal of electrode array)	35.52	90

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

	Svy CPT 61567	Ref CPT 61536 HVD
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey Response Count	20	--
Pre-service	120	48
Intra-service	280	298
Same Day Immediate Post-service	45	65
Critical care	0	0
Other hospital visit	106	165.8
Discharge day management	36	
Office visit	76	52.5
<b>TOTAL TIME</b>	<b>663</b>	<b>629</b>

**INTENSITY/COMPLEXITY MEASURES (mean)**

Survey Response Count	10	10
-----------------------	----	----

**TIME SEGMENTS**

Pre-service	4.71	4.29
Intra-service	4.86	4.57
Post-service	3.86	3.71

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	4.29	4.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	4.57
Urgency of medical decision making	3.43	3.43

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	4.57	4.00
Physical effort required	4.29	3.86

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	4.86	4.29
Outcome depends on the skill and judgment of physician	4.57	4.29
Estimated risk of malpractice suit with poor outcome	4.29	3.86

## ADDITIONAL RATIONALE

### 1. Discussion of time and complexity/intensity comparison

The survey median RVW of 35.50 for 61567 is recommended.

This is a fairly new epilepsy surgery, performed over the last 10 years in highly selected epilepsy centers. The procedure involves a large hemispherical craniotomy and extensive intraoperative electrocorticography. In comparison, the reference code involves a similar craniotomy and resection of an epileptogenic focus defined by electrocorticography. 61567 is performed in regions of the brain that give rise to seizures, but cannot be resected without harm (typically language cortex or motor cortex). The procedure involves dissection to disconnect the horizontal cortical connections and to preserve the vertical axons, thus limiting seizure spread without removing this "eloquent" brain. This must be performed without interrupting the blood supply to that cortex. As such, this is a more intense procedure which carries a higher risk of serious complications. Although the time is less, the intensity, as reflected also in the IWPUT of 0.091, is in keeping with the intensity of other high risk intracranial procedures. We are recommending the survey median RVW of 35.50 for 61567.

### 2. IWPUT Analysis

ROW / COLUMN	A	B	C	D	E	F	
1	<b>61567 and 31536</b>	<b>61567 Svy Data</b>	<b>Svy RVW: RUC Std.</b>	<b>35.50 RVW</b>	<b>61536 Svy Data</b>	<b>MFS RVW: RUC Std.</b>	<b>35.52 RVW</b>
2							
3	<b>Pre-service:</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>
4	Pre: eval & posit	100	0.0224	2.24	28	0.0224	0.63
5	Pre: scrub,dress,wait	20	0.0081	0.16	20	0.0081	0.16
6	<b>Pre-service total</b>			<b>2.40</b>			<b>0.79</b>
7	<b>Post-service:</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>	<b>Time</b>	<b>Intensity</b>	<b>(=time x ints'y)</b>
8	Immediate post	45	0.0224	1.01	65	0.0224	1.46
9	<b>Subsequent visits:</b>	<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>	<b>Visit n</b>	<b>E/M RVW</b>	<b>(=n x RVW)</b>
10	ICU 99291		4.00			4.00	
11	99233		1.51			1.51	
12	99232	1	1.06	1.06		1.06	
13	99231	4	0.64	2.56	12	0.64	7.68
14	Discharge 99238	1	1.28	1.28	1	1.28	1.28
15	Discharge 99239		1.75			1.75	
16	99214		1.08			1.08	
17	99213	2	0.65	1.30	2.5	0.65	1.63
18	99212	2	0.43	0.86		0.43	
19	99211		0.17			0.17	
20	<b>Post-service total</b>			<b>8.07</b>			<b>12.04</b>
21	<b>Intra-service:</b>	<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>	<b>Time</b>	<b>IWPUT</b>	<b>INTRA-RVW</b>
22	<b>Intra total</b>	<b>275</b>	<b>0.091</b>	<b>25.03</b>	<b>298</b>	<b>0.076</b>	<b>22.69</b>

**Services Reported with Multiple CPT Codes**

1. Is this new/revised code typically reported on the same date with other CPT codes?  
Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

<input checked="" type="checkbox"/>	The surveyed code is <del>an add-on code or a base code expected to</del> that may be reported with an add-on code.
<input checked="" type="checkbox"/>	Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
<input checked="" type="checkbox"/>	Multiple codes allow flexibility to describe exactly what components the procedure included.

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes.

work				
CPT	Glob	RVW	NS	Neurology
61567	090	35.50	35.50	
69990	ZZZ	3.47	3.47	
95829	XXX	6.21		6.21
<b>TOTAL RVW by Specialty</b>			<b>38.97</b>	<b>6.21</b>

time		
CPT	NS	Neurology
61567	663	
69990	n/a*	
95829		87
<b>TOTAL RVW by Specialty</b>	<b>663*</b>	<b>87</b>

\*69990 *Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)* A specific intra-operative time is not associated with this code. Use of the operating microscope will add time and intensity to any operation, when employed.

\*\*95829 *Electrocorticogram at surgery (separate procedure)*

**FREQUENCY INFORMATION**

**How was this service previously reported?**

The service may have been coded using: 64999 Unlisted procedure, nervous system

**How often do physicians in your specialty perform this service?**

Specialty: Neurosurgery                      Commonly — Sometimes                      **Rarely**

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Neurosurgery                      Frequency: Less than 100

**For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?**

Specialty: Neurosurgery                      Frequency: Less than 25

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

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
090 Day Global Period  
Facility Direct Inputs**

<b>CPT</b>	<b>DESCRIPTION</b>	<b>GLOBAL</b>
<b>61537</b>	Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, without electrocorticography during surgery	<b>90</b>
<b>61540</b>	Craniotomy with elevation of bone flap; for lobectomy, other than temporal lobe, partial or total; without electrocorticography during surgery	<b>90</b>
<b>61566</b>	Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy	<b>90</b>
<b>61567</b>	Craniotomy with elevation of bone flap; for multiple subpial transections; with electrocorticography during surgery	<b>90</b>

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:** The direct practice expense details were crosswalked from previously PEAC approved details for the neurosurgery craniotomy family codes. For additional supply items, see attached RUC approved "standard" neurosurgery post-operative incision care kit.

**CLINICAL STAFF TYPE:**  
RN/LPN/MA 1130

**CLINICAL STAFF TIME:**  
**Pre-service period clinical staff time (prior to admission):** For each of these 90-day facility only procedures, the standard "typical" 60 minutes have been applied.

**Service period clinical staff time (admission to discharge):**  
Pre-service: N/A  
Intra-service: N/A  
Post-service: 12 minutes of clinical staff time for work related to facility discharge (99238 level).

**Post-service period clinical staff time:** Standard EM postop visit time for clinical staff has been applied for each office visit.

**SUPPLIES AND EQUIPMENT:**  
Minimum visit package (multispecialty) for each post-op visit.  
Post-op incision care kit at first post-op visit.  
Suture removal kit; tincture benzoin swab; gauze,sterile 4 x 4; kling roller bandage 2 x 131; and tape at first post-op visit.  
Patient education booklet on day of discharge.

**SUPPLIES AND EQUIPMENT:**  
Power table and exam lamp for post-op visits.

**RUC APPROVED STANDARD SUPPLY PACKAGE (2002):**

**PEAC Pack compared with the NS Post-Op Incision Care Kit for Craniotomy**

<u>Code</u>	<u>Description</u>	<u>Unit</u>	<u>PEAC post-op pack</u>	<u>Standard</u>	<u>Craniotomy</u>	<u>Spine</u>	<u>Periph Nerv</u>
14005	Gloves, sterile	pair	1	1	1	1	1
11302	Swab, alcohol	item	2	2	2	2	2
31505	Gauze, Sterile 4 x 4	item	2	2	4-2*	4	2
31513	Steri-strips	strip	12	12	12	12	12
31514	Tape	inch	12	12	60-12*	36	18
31702	Staple removal kit	item	1	1	1	1	1
52301	Betadine	ml	20	20	20	20	20
52308	Tincture benzoin swab	item	1	1	2-1*	2	1
31703	Suture removal kit	item	0	1	1	1	0
31509	Kling roller bandage 2 x 131	item	0	0	1-0*	0	1
11115	Patient education booklet	item	0	1	1-0*	1	1

\*Additional Quantities or Items not included in PEAC post-op incision care kit have been added on the attached worksheet.

61537-61567 PE Details (April 2003 RUC)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	61537		61540	
		Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, without electrocorticography during surgery		Craniotomy with elevation of bone flap, for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery	
GLOBAL PERIOD		90		90	
LOCATION		NonFac	Fac	NonFac	Fac
<b>TOTAL CLINICAL LABOR TIME</b>	1130	N/A	171.0	N/A	171.0
PRE-SERVICE PERIOD TOTAL TIME	1130		60.0		60.0
SERVICE PERIOD TOTAL TIME	1130		12.0		12.0
POST-SERVICE PERIOD TIME	1130		99.0		99.0
<b>PRE-SERVICE PERIOD</b>					
Complete pre-service diagnostic & referral forms	1130		5		5
Coordinate pre-surgery services	1130		20		20
Schedule space and equipment in facility	1130		8		8
Provide pre-service education/obtain consent	1130		20		20
Follow-up phone calls & prescriptions	1130		7		7
Other Clinical Activity (please specify)					
<b>SERVICE PERIOD</b>					
Pre-service			0		0
Intra-service			0		0
Post-Service					
Discharge day management 99238 --12 minutes 99239 --15 minutes	1130		12		12
Other Clinical Activity (please specify)					
<b>POST-SERVICE PERIOD</b>					
Conduct phone calls/call in prescriptions					
List Number and Level of Office Visits					
99211 16 minutes					
99212 27 minutes			1		1
99213 36 minutes			2		2
99214 53 minutes					
99215 63 minutes					
<b>Total Office Visit Time</b>	1130	0	99	0	99
Other Activity (please specify)					
<b>MEDICAL SUPPLIES</b>					
minimum visit package (multispecialty)	PEAC pack		3		3
post-op incision care kit	PEAC kit		1		1
Additional incision care supplies					
suture removal kit	31703		1		1
tincture benzoin swab	52308		1		1
Gauze, Sterile 4 x 4	31505		2		2
klings roller bandage 2 x 131	31509		1		1
tape	31514		48		48
<b>Equipment</b>					
power table	E11003		1		1
exam lamp	E30006		1		1

61537-61567 PE Details (April 2003 RUC)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	61566 Craniotomy with elevation of bone flap, for selective amygdalohippocampectomy		61567 Craniotomy with elevation of bone flap, for multiple subpial transections; with electrocorticography during surgery	
		NonFac	Fac	NonFac	Fac
GLOBAL PERIOD		90		90	
LOCATION		NonFac	Fac	NonFac	Fac
TOTAL CLINICAL LABOR TIME	1130	N/A	171.0	N/A	198.0
PRE-SERVICE PERIOD TOTAL TIME	1130		60.0		60.0
SERVICE PERIOD TOTAL TIME	1130		12.0		12.0
POST-SERVICE PERIOD TIME	1130		99.0		126.0
<b>PRE-SERVICE PERIOD</b>					
Complete pre-service diagnostic & referral forms	1130		5		5
Coordinate pre-surgery services	1130		20		20
Schedule space and equipment in facility	1130		8		8
Provide pre-service education/obtain consent	1130		20		20
Follow-up phone calls & prescriptions	1130		7		7
Other Clinical Activity (please specify)					
<b>SERVICE PERIOD</b>					
Pre-service			0		0
Intra-service			0		0
Post-Service					
Discharge day management 99238 --12 minutes 99239 --15 minutes	1130		12		12
Other Clinical Activity (please specify)					
<b>POST-SERVICE PERIOD</b>					
Conduct phone calls/call in prescriptions					
<i>List Number and Level of Office Visits</i>					
99211 16 minutes					
99212 27 minutes			1		2
99213 36 minutes			2		2
99214 53 minutes					
99215 63 minutes					
<b>Total Office Visit Time</b>	1130	0	99	0	126
Other Activity (please specify)					
<b>MEDICAL SUPPLIES</b>					
minimum visit package (multispecialty)	PEAC pack		3		3
post-op incision care kit	PEAC kit		1		1
<b>Additional incision care supplies</b>					
suture removal kit	31703		1		1
tincture benzoin swab	52308		1		1
Gauze, Sterile 4 x 4	31505		2		2
klings roller bandage 2 x 131	31509		1		1
tape	31514		48		48
<b>Equipment</b>					
power table	E11003		1		1
exam lamp	E30006		1		1

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Deep Brain Stimulation**

The CPT Editorial Panel has created the following four codes to accurately describe the work associated with deep brain stimulation (DBS) with and without the use of intra-operative microelectrode recording (MER).

61863

Code 61862 *Twist drill, burr hole, craniotomy, or craniectomy for stereotactic implantation of one neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray); with use of intraoperative microelectrode recording* (2003 MFS RVU = 19.34, 27.34 was a previous RUC recommendation) includes a mixture of cases that included MER along with cases that did not use MER. This code is being deleted and replaced by 61863 *Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array* and 61867 *Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array*. The specialty society convened a consensus committee to review the results of the surveys and to determine the appropriate work RVU recommendation. The consensus committee reviewing these codes estimated that the split between 61863 and 61867 will be approximately 40:60. Recommendations for 61863 and 61867 were created in tandem in an effort to: 1) maintain work neutrality; 2) approximate the survey data; and 3) allow for a work RVU spread between 61863 and 61867 to account for 160 minutes of additional intra-operative time.

To accomplish the first task, the specialty society's consensus panel reviewed the 2001 CMS utilization information on 61862. In the 2001 CMS utilization file there was 951 allowed claims for 61862. This number multiplied by 27.34 RVWs equals 26,000 RVUs (27.34 is the RUC approved RVW for 61862 and after reviewing the time/motion analysis, CMS also accepts that this value more closely approximated the work of 61862). After looking at the utilization information and the surveys, the consensus panel estimated that the split between 61863 and 61867 will be 40:60. Therefore, by using the 2001 CMS utilization information on 61862 (951 allowed claims), they approximated the utilization of 61863 to be 380 claims and estimated the utilization of 61867 to be 571 claims. Then, the consensus panel, took the utilization data for 61862, 951 allowed claims, and multiplied this number by the 27.34 RVWs, the RUC accepted work RVU for this code, which resulted in a total of 26,000 RVUs. The specialty society determined that the total recommended RVUs for 61863 and 61867 should not exceed this total RVUs amount in order to maintain work neutrality.

To accomplish the second and third task, the consensus panel reviewed the survey results and wanted to approximate the 25<sup>th</sup> percentile of the recommended work RVU (25<sup>th</sup> percentile recommended work RVU = 18.50). However, the consensus panel felt that the 25<sup>th</sup> percentile recommended work RVU was slightly conservative and felt that a recommendation of 19.00 work RVU was a more appropriate value for 61863. Therefore, when the consensus panel multiplied the 19.00 recommended work RVU for 61863 by the estimated utilization of this code, 380 claims, it resulted in 7,220 total RVUs. This same process was done for 61867 with a recommended work RVU of 31.34, slightly less than the 75<sup>th</sup> percentile recommended work RVU. This process resulted in 17,895 total RVUs for 61867. When the total RVUs for both 61863 and 61867 were added it closely approximated the total RVUs for 61862; 25,115 and 26,000 respectively. These calculations are shown in the table below.

Code	Split	'01 Util.	RVUs	RVW
61863	40%	380	7,220	19.00
61867	60%	571	17,895	31.34
61862	100%	951	26,000	27.34

The RUC agreed with the specialty society's rationale behind their work RVU recommendation for 61863. **Therefore, the RUC recommends a work relative value of 19.00 61863.**

#### 61864

The RUC examined code 61864 *Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array*. It was determined by the RUC after reviewing the reference code 63076 *Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)* (Work RVU = 4.05) that the intra-service time of the surveyed code (intra-service time = 68 minutes) is more than the intra-service time of the reference code (intra-service time = 63 minutes). In addition, the RUC agreed that the intensity of the surveyed code exceeded the intensity of the reference code. Therefore, the RUC agreed with the specialty society that the increased time and intensity required to perform this procedure support the specialty society's median value of their survey (work RVU = 4.50) which is minimally higher than the relative work associated with the reference code (Work RVU = 4.05). **The RUC recommends a work relative value of 4.50 for 61864.**

#### 61867

The RUC examined code 61867 *Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array*. The specialty society initially had requested the 75<sup>th</sup> percentile (33.00 RVUs)

surveyed results for this long intense surgical procedure. The presenters provided an extensive description of the service, as well as a more detailed explanation of their survey results. The RUC understood that this procedure is quite lengthy with the use of intra operative microelectrode recording. In addition, the physician work intensity was comparable to new CPT code 61863 *Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array* (Recommended work RVU = 19.00) which was adopted by the RUC. The RUC believed that the survey respondents may have been underestimating the true time and work involved in the procedure, as the median survey results were lower given the direct correlation between time and intensity of 61863 to 61867.

The RUC reasoned that since the intra service work of 61863 is quite similar to 61867 within the new family of codes, the intensity of 61863 multiplied by the total median time for 6816X3 of 300 minutes plus the pre-service and post service work components results in a more reasonable and appropriate relative work value of 31.34 for the 61867. This work valuation would keep the proper rank order for the family of codes and represent the true physician work. Calculations are listed below.

$$\begin{array}{rcccccc}
 300 \text{ Minutes} & & \times & & 0.078 & & = & & 23.40 \\
 \text{Intra-service time of 61867} & & & & \text{IWPUT of 61863} & & & & \text{Intra-Service-RVW of 61867} \\
 \\ 
 23.40 & & + & & 1.80 & & + & & 6.14 & & = & & 31.34 \\
 \text{Intra-Service RVW of 61867} & & \text{Pre-Service RVW of 61867} & & & & \text{Post-Service RVW of 61867} & & \text{Recommended RVW} & & & & \text{of 61867}
 \end{array}$$

Based on these assumptions, and the typical patient encounter, **the RUC recommends a relative work value of 31.34 for 61867.**

### 61868

The RUC examined 61868 *Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; each additional array*. The RUC determined that 61868 is an add on code to 61867 and similarly was determined to correlate directly with the intra-service work per unit of time of 61864 *Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array*; (Recommended work RVU = 4.50) which was adopted by the RUC. 61864 is also an add on code, but without the use of intra operative microelectrode recording. Members of the RUC believed that the intra-service work per unit of time for 61864, 0.066, multiplied by the median time of 61868, 120 minutes, would provide the appropriate work relative value. Calculations are listed below.

$$\begin{array}{rclcl} 0.066 & \times & 120 \text{ Minutes} & = & 7.92 \\ \text{IWPUT of 61864} & & \text{Intra Service Time of 61868} & & \text{Recommended RVW for 61868} \end{array}$$

In addition, the committee believed this would keep the rank order of this new set of codes. **The RUC recommends a relative work value of 7.92 for 61868.**

Practice Expense

The direct practice expense inputs were cross-walked from previously PEAC approved inputs for the neurosurgery family of codes for twist drill/burr hole procedures and RUC approved “standard” neurosurgery post-operative incision care kit. The practice expense inputs were approved by the RUC.

CPT Code (•New)	Tracking Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Codes 61580-61888 apply to both simple and complex neurostimulators. For initial or subsequent electronic analysis and programming of neurostimulator pulse generators, see codes 95970-95975</p> <p><u>Microelectrode recording when performed by the operating surgeon in association with implantation of neurostimulator electrode arrays is an inclusive service and should not be reported separately. If another physician participates in neurophysiological mapping during a deep brain stimulator implantation procedure, this service may be reported by the other physician with codes 95961-95962.</u></p>				
61862		<p><del>Twist drill, burr hole, craniotomy, or craniectomy for stereotactic implantation of one neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray); with use of intraoperative microelectrode recording</del></p> <p><u>(Code 61862 has been deleted. To report, see 61867, 61868.)</u></p>	090	N/A

CPT Code (•New)	Tracking Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●61863	EE1	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), <b>without</b> use of intraoperative microelectrode recording; <b>first</b> array	090	19.00
●+61864	EE2	<p style="text-align: center;"><b><u>each additional array</u></b></p> <p>(List separately in addition to primary procedure) (Use 61864 in conjunction with code 61863)</p>	ZZZ	4.50
●61867	EE3	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), <b>with</b> use of intraoperative microelectrode recording; <b>first</b> array	090	31.34
●+61868	EE4	<p style="text-align: center;"><b><u>each additional array</u></b></p> <p>(List separately in addition to primary procedure) (Use 61868 in conjunction with code 61867)</p>	ZZZ	7.92

---

**CPT Code:** 61863      **Tracking No:** EE1      **Global:** 090      **Recommended RVW:** 19.00

**CPT Descriptor:** Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array

---

**Typical Patient:** A 66-year-old woman presents with a ten-year history of idiopathic Parkinson's disease that has caused progressive disability. She continues to respond to antiparkinson medications, however; her symptoms are no longer adequately controlled with medications and she is experiencing disability for many activities of daily living. Medication adjustments and different medication regimens have failed to improve her level of disability. She undergoes implantation of a stereotactically-guided deep brain stimulator electrode array in the subthalamic nucleus using macro stimulation for targeting and confirmation of electrode placement.

---

## CLINICAL DESCRIPTION OF SERVICE

### Description of Pre-Service Work:

Pre-service work includes review of records and any pertinent imaging studies; communicating with other professionals, patient, and family; and obtaining consent. The use of anti-Parkinson medications is stopped 24 hours before the procedure.

### Description of Intra-Service Work:

Prior to surgery, a local anesthetic is administered and a stereotactic frame is attached using pins to anchor the frame to the skull (inherent/bundled). Care is taken to align the frame with the inferior rim of the orbit and the external auditory meatus and to keep the frame level with the head. The surgeon accompanies the patient to the radiology department to obtain a CT or MRI scan (separately reportable with codes 70551 or 70450). The surgeon aligns the patient in the scanner. After the scans are performed, the surgeon plans the stereotactic surgery with computer assistance. This planning includes identifying MRI or CT marker points and the desired target; determining the coordinates for the target; measuring the AC-PC line; and calculating angles. Using a computer, various trajectories for the electrode placement to reach the target are examined before choosing one specific trajectory and calculating the entry point through the skull based upon safety and target coverage considerations using an anatomic atlas of the basal ganglia. After planning is complete, the patient returns to the OR and the surgeon helps position the patient on the operating table. While the patient is prepped and draped, the surgeon scrubs for the procedure.

Components of the frame are assembled, and the coordinates of the entry point are entered into the stereotactic arc system. The entry point is localized with the stereotactic arc and the incision is marked. Under IV sedation, the skin is infiltrated with local anesthetic. The previously marked incision is opened. The wound edge is retracted and hemostasis is obtained with electrocautery. A cranial drill is used to make a single twist drill or burr hole 25-35 mm from the midline at the level of the coronal suture. The dura is coagulated and punctured. The entry point of the guide cannula is inspected and the brain surface is coagulated, taking care to avoid major cortical vessels. Next, the electrode guide is attached to the stereotactic arc, and a guide cannula inserted into the brain. The deep brain stimulation array is introduced to the selected target point. Test stimulation is carried out, testing for tremor suppression, reduced rigidity, limb mobility and coordination as well as possible side effects. The electrode array is repositioned and re-stimulated as many times as necessary to obtain the best degree of tremor suppression and least side effects. Periodic examination of relevant neurologic functions and the effect of trial stimulation is performed by either the operating surgeon. When optimal placement of the electrode is confirmed, the guide cannula is removed from the brain, leaving the electrode array in place. This procedure is usually monitored radiographically (fluoroscopic and/or x-ray, inherent/bundled) to assure that the electrode array has not changed position. The electrode array is fastened in place using an anchoring device. Absolute hemostasis is obtained. The lead is coiled in a subgaleal pocket. Galea is closed with sutures and the skin is closed with sutures or staples. Sterile dressings are applied, and the stereotactic frame is removed. The four pin sites are dressed.

**Description of Post-Service Work:**

Postoperative work includes checking the external connections of the electrode to testing cables; communicating with the family and other health care professionals (including written and oral reports and orders); monitoring the patient's neurological condition for any deficits from either electrode placement and/or the stimulation itself; monitoring for wound infection; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient; review with the patient and family of post-discharge continuing care and instructions; resumption of the pre-surgical medications, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of staples and sutures; monitoring wound healing; and examining the patient in the office at appropriate postoperative intervals to ensure adequate healing of all wounds.

**SURVEY DATA**

<b>Presenter(s):</b>	Robert Florin, MD; Jeffrey Cozzens, MD				
<b>Specialty(s):</b>	American Society for Stereotactic and Functional Neurosurgery American Association of Neurological Surgeons/Congress of Neurological Surgeons				
<b>CPT Code:</b>	<b>61863</b>				
<b>Sample Size:</b>	130	<b>Resp n:</b>	36	<b>Resp %:</b>	28%
<b>Sample Type:</b>	Random - ASSFN; Random AANS subsection of stereotactic neurosurgery				
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		18.00	18.50	22.00	26.00
<b>Pre-Service Evaluation Time:</b>				45	
<b>Pre-Service Positioning Time:</b>				15	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				15	
<b>Intra-Service Time:</b>		90	120	140	210
<b>Post-Service</b>	<b>Total Min<sup>1</sup></b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	30				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	79	99232 x 2; 99231 x 1			LOS =4
<b>Discharge Day Mgmt:</b>	36	99238			
<b>Office time/visit(s):</b>	69	99213 x 3			

<sup>1</sup>Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
61863	<i>Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array</i>	Recom'd 19.00	090
61735	Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; subcortical structure(s) other than globus pallidus or thalamus	20.43	090

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

	Survey CPT 61863	Primary Ref 61735 HVD
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey response count	36	--
Pre-service	75	39
Intra-service	140	184
Same Day Immediate Post-service	30	60
Critical care	0	131.8
Other hospital visit	79	
Discharge day management	36	
Office visit	69	52.5
<b>TOTAL TIME</b>	429	467

**INTENSITY/COMPLEXITY MEASURES (mean)**

Survey response count	10	10
<b>TIME SEGMENTS</b>		
Pre-service	4.50	4.40
Intra-service	4.50	4.00
Post-service	3.40	2.70
<b>MENTAL EFFORT AND JUDGMENT</b>		
The number of possible diagnosis and/or the number of management options that must be considered	4.40	4.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	4.30
Urgency of medical decision making	3.10	3.00
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>		
Technical skill required	4.60	4.10
Physical effort required	3.40	3.10
<b>PSYCHOLOGICAL STRESS</b>		
The risk of significant complications, morbidity and/or mortality	4.40	4.30
Outcome depends on the skill and judgment of physician	4.90	4.40
Estimated risk of malpractice suit with poor outcome	3.90	3.90

## ADDITIONAL RATIONALE

**The following rationale applies to both 61863 and 61867.**

### 1. Background

Current code, 61862 *Twist drill, burr hole, craniotomy, or craniectomy for stereotactic implantation of one neurostimulator array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray)* was presented to the RUC in May 1999. The RUC supported the proposed work recommendation of 27.34 for 61862. The RUC database rationale states:

This value was determined using the building block approach: 1) The stereotactic work is similar to CPT 61795 Stereotactic computer assisted volumetric intracranial procedure (work RVU=4.04); 2) The portion of the work done in the operating room includes those services in the deleted codes based on the estimated frequency of 4:1 (eg, 80% 61855 and 20% 61865)=15.30; and lastly, 3) The final intraoperative element to be included is the testing and repositioning of the electrode array. Using the survey median intraoperative time of 320 minutes and subtracting 120 minutes (for stereotactic work) and 60 minutes (for opening the skull, placing the electrode, and closing after testing, = 140 minutes. This number is equivalent to two hours of critical care management (CPT 99291/99292)=8.00. The sum of these estimates equals the RUC recommended value of 27.34.

In the November 1999 Final Rule, CMS disagreed with the RUC's recommendation using the following rationale:

The RUC evaluated this code (61862) with a building block approach that included the work of stereotactic localization, the device implantation, and 140 minutes of intraoperative testing contributing 8.00 work RVUs. The RUC recommendation for the entire procedure is 27.34 work RVUs. Because the time for intraoperative testing is variable, we are subtracting 8.00 work RVUs and assigning a value for the procedure of 19.34. We are advising using CPT codes 95961 (work RVUs of 2.97) and 95962 (work RVUs of 3.21), functional cortical and subcortical mapping, to report the work of intraoperative testing. We also note that since the work of stereotactic localization is included in 61862, we will deny payment for other stereotactic localization codes billed in conjunction with this code.

Comments offered to CMS regarding this reduction, were addressed and rejected by CMS. 61862 was also submitted to the RUC during the second five year review to confirm the initial valuation of 27.34, was again approved by the RUC, forwarded to CMS, and was again rejected by CMS.

In 2001, an independent survey of the time and work for this procedure was initiated after many complaints about the *relative* RVW for a procedure of this duration and complexity. Videotapes of entire operative sessions of 61862 were analyzed to identify the amount of time required for each phase of the intra-service portion of the procedure. A series of 30 such tapes were eventually compiled into a time/motion study with detailed analysis and calculation of the median time for each phase. It clearly demonstrated that the neurosurgeon was an active, and sometimes solo, participant in the disputed microelectrode recording phase of the procedure. The analysis also demonstrated that the neurosurgeon was integral to the placement of the stimulating electrode as well as the interpretation of information from the recordings in collaboration with a neurologist (if present).

This information was reviewed with CMS in September 2002, and after study of the time/motion data, CMS advised that the data had revealed three distinct subsets of the original procedure, 61862. This included the procedure without microelectrode recording (MER), and two add-on components for a second side both with and without MER. CMS recommended that new CPT codes be developed for these variants and then present new survey data for revaluation of the base code as well as the three variants as described. CPT codes were developed and assigned at the February 2003 CPT Editorial Panel and are now presented for RUC valuation.

## 2. Time comparison

The time/motion study of two patients for 61863 had an intra-service time of 131 minutes, while the RUC survey had 36 respondents with a time of 140 min. The time/motion study had 13 cases for 61867 with a median intra-service time of 320 min, while the RUC survey had 36 respondents with a time of 300 min.

The median intra-service time for 61863 of 140 minutes was reviewed by the specialty review committee and is reasonable as compared to the reference code. In the initial valuation of code 61862, the RUC included 140 min. for microelectrode recording and stimulation (MER). The intra-service time for 61867 is 300 min., which is the same as 61863, but includes MER. The difference in intraoperative time between 61863 (w/o MER) and 61867 (w/MER) is 160 min. (=300-140). This is only slightly more than the RUC's earlier *estimate* of 140 minutes for MER included in the RUC's building block evaluation of its recommendation for 61862.

## 3. Complexity/Intensity

Comparison of the survey complexity and intensity means for 61863 to 61735 are all higher with the exception of the last item. For 61867 to 61735, the means are all higher.

## 4. Recommendation

Code 61862 includes an admixture of cases that included MER along with cases that did not use MER. This code is being deleted and replaced by 61863 (without MER) and 61867 (with MER). The consensus committee reviewing these codes have estimated that the split between 61863 and 61867 will be 40:60. Recommendations for 61863 and 61867 were created in tandem in an effort to: 1) maintain budget neutrality; 2) approximate the survey data; and 3) allow for an RVW spread between 61863 and 61867 to account for 160 minutes of additional intraoperative time.

In the 2001 CMS utilization file, there were 860 allowed claims (without modifier) for 61862. This number multiplied by 27.34 RVWs equals 23,512 RVU's (27.34 is the RUC approved RVW for 61862, and, after reviewing the time/motion analysis, CMS also accepts that this value more closely approximates the work of 61862). Using an algebraic formula (data shown below), **an RVW of 19.00 is recommended for 61863 and an RVW of 33.00 is recommended for 61867.**

Code	Split	'01 Util.	RVUs	RVW
<b>61863</b>	40%	348	9,506	<b>19.00</b>
<b>61867</b>	60%	512	14,007	<b>33.00</b>
<i>61862</i>	<i>100%</i>	<i>860</i>	<i>23,512</i>	<i>27.34</i>

These recommend RVWs for 61863 and 61867 accomplish all three goals outlined above. 1) The total RVUs do not change. 2) The values approximate the spread of survey RVWs, going lower for 61863 and higher for 61867. 3) The spread of RVUs between 61863 and 61867 at 14.00 is reasonable for 160 minutes of additional intraoperative time (iwput=0.08). Additionally, these new values appropriately set the IWPUT for 61867 slightly higher than for 61863 (see tables below). Use of the survey medians would not have accomplished any of these goals and would have created a work anomaly between the codes.

**IWPUT using survey median RVWs:** This shows how the survey medians would create an anomaly between the work of 61863 and 61867.

ROW / COLUMN	A	B	C	D	E	F
1	61863	Svy RVW:	22.00	61867	MFS RVW:	28.80
2	Svy Data	RUC Std.	RVW	Svy Data	RUC Std.	RVW
3	<b>Pre-service:</b>	Time	Intensity (=time x ints'y)	Time	Intensity (=time x ints'y)	
4	Pre: eval & posit	60	0.0224	1.34	65	0.0224
5	Pre: scrub,dress,wait	15	0.0081	0.12	15	0.0081
6	<b>Pre-service total</b>		1.47			1.80
7	<b>Post-service:</b>	Time	Intensity (=time x ints'y)	Time	Intensity (=time x ints'y)	
8	Immediate post	30	0.0224	0.67	30	0.0224
9	<b>Subsequent visits:</b>	Visit n	E/M RVW (=n x RVW)	Visit n	E/M RVW (=n x RVW)	
10	ICU 99291		4.00			4.00
11	99233		1.51			1.51
12	99232	2	1.06	2.12	2	1.06
13	99231	1	0.64	0.64	1	0.64
14	Discharge 99238	1	1.28	1.28	1	1.28
15	Discharge 99239		1.75			1.75
16	99214		1.08			1.08
17	99213	3	0.65	1.95	3	0.65
18	99212		0.43			0.43
19	99211		0.17			0.17
20	<b>Post-service total</b>		6.66			6.14
21	<b>Intra-service:</b>	Time	IWPUT	INTRA-RVW	Time	IWPUT
22	<b>Intra total</b>	140	0.099	13.87	300	0.069

**IWPUT using recommended RVWs:** This shows an appropriate relationship between 61863 and 61867.

ROW / COLUMN	A	B	C	D	E	F
1	61863	Svy RVW:	19.00	61867	MFS RVW:	33.00
2	Svy Data	RUC Std.	RVW	Svy Data	RUC Std.	RVW
3	<b>Pre-service:</b>	Time	Intensity (=time x ints'y)	Time	Intensity (=time x ints'y)	
4	Pre: eval & posit	60	0.0224	1.34	65	0.0224
5	Pre: scrub,dress,wait	15	0.0081	0.12	15	0.0081
6	<b>Pre-service total</b>		1.47			1.80
7	<b>Post-service:</b>	Time	Intensity (=time x ints'y)	Time	Intensity (=time x ints'y)	
8	Immediate post	30	0.0224	0.67	30	0.0224
9	<b>Subsequent visits:</b>	Visit n	E/M RVW (=n x RVW)	Visit n	E/M RVW (=n x RVW)	
10	ICU 99291		4.00			4.00
11	99233		1.51			1.51
12	99232	2	1.06	2.12	2	1.06
13	99231	1	0.64	0.64	1	0.64
14	Discharge 99238	1	1.28	1.28	1	1.28
15	Discharge 99239		1.75			1.75
16	99214		1.08			1.08
17	99213	3	0.65	1.95	3	0.65
18	99212		0.43			0.43
19	99211		0.17			0.17
20	<b>Post-service total</b>		6.66			6.14
21	<b>Intra-service:</b>	Time	IWPUT	INTRA-RVW	Time	IWPUT
22	<b>Intra total</b>	140	0.078	10.87	300	0.083

**Services Reported with Multiple CPT Codes**

- Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions:

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

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

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

CPT	RVW					
	Glob	RVW	NS	Assistant	Neurology	Radiology
<b>61863:</b> Twist drill, ....., <b>without</b> use of intraoperative microelectrode recording; <b>first</b> array	90	19.00	19.00	3.04		
<b>95961:</b> Functional cortical and subcortical mapping by stim &/or recording of electrodes in brain, or depth electrodes, ... initial hour	XXX	2.97			2.97	
<b>95962:</b> Functional cortical and subcortical mapping by stim &/or recording of electrodes in brain, or depth electrodes, ... initial addl hour	XXX	3.21			3.21 x 2	
<b>70450:</b> CT, brain, w/o contrast	XXX	0.85				0.85
<b>70551:</b> Magnetic resonance imaging w/o contrast	XXX	1.48				1.48
<b>TOTAL RVW by Specialty</b>			<b>19.00</b>	<b>3.04</b>	<b>9.39</b>	<b>1.48</b>

CPT	TIME			
	NS	Asst	Neurology	Radiology
<b>61863:</b> Twist drill, ....., <b>without</b> use of intraoperative microelectrode recording; <b>first</b> array	429	140		
<b>95961:</b> Functional cortical and subcortical mapping by stim &/or recording of electrodes in brain, or depth electrodes, . . . initial hour			65 ("pr")	
<b>95962:</b> Functional cortical and subcortical mapping by stim &/or recording of electrodes in brain, or depth electrodes, ... initial addl hour			140 ("pr")	
<b>70450:</b> CT, brain, w/o contrast				17 ("pr")
<b>70551:</b> Magnetic resonance imaging w/o contrast				28 ("pr")
<b>TOTAL RVW by Specialty</b>	<b>429</b>	<b>140</b>	<b>180</b>	<b>45</b>

**FREQUENCY INFORMATION****How was this service previously reported?**

61862 *Twist drill, burr hole, craniotomy, or craniectomy for stereotactic implantation of one neurostimulator array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray)*

However, use of this code would be inaccurate since it was valued to include intraoperative microelectrode recording. Confusion arose because the descriptor did not state this.

**How often do physicians in your specialty perform this service?**

Specialty: Neurosurgery                      ~~Commonly~~      Sometimes      Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Neurosurgery

Frequency: Medicare utilization data shows a utilization for 2001 of 860 cases. However, many of these procedures are done on patients under 65 years. The exact number is not known.

**For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?**

Specialty: Neurosurgery

Frequency: In 2001, there were 860 Medicare claims for 61862 (no modifier). It is estimated that the split of 61862 into 61863 and 61867 will be 40% to 60%.

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

---

---

CPT Code: 61864      Tracking No: EE2      Global: ZZZ      Recommended RVW: 4.50

**CPT Descriptor:** Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), **without** use of intraoperative microelectrode recording; **each additional array**

---

**Typical Patient:** A 66-year-old woman presents with a ten-year history of idiopathic Parkinson's disease that has caused progressive disability. She continues to respond to antiparkinson's medications, however; her symptoms are no longer adequately controlled with medications and she is experiencing disability for many activities of daily living. Medication adjustments and different medication regimens have failed to improve her level of disability. She undergoes implantation of a second stereotactically-guided deep brain stimulator electrode array in the subthalamic nucleus using macro stimulation for targeting and confirmation of electrode placement. [Note: only consider the "additional" work related to implantation of a second array.]

---

## CLINICAL DESCRIPTION OF SERVICE

### Description of Intra-Service Work:

After the scans are performed and first target plotted, the surgeon plans the stereotactic surgery for the second target with computer assistance. This planning includes identifying MRI or CT marker points bilaterally and the desired targets; determining the coordinates for the targets; measuring the AC-PC line; and calculating angles. Using a computer, various trajectories for the electrode placement to reach the targets are examined before choosing one specific trajectory and calculating the entry point through the skull based upon safety and target coverage considerations using an anatomic atlas of the basal ganglia. After implantation of the first electrode array, the scalp is re-prepped and draped for the second electrode implantation and the surgeon scrubs.

The skin on the second side is infiltrated with local anesthetic. A linear incision is made just anterior to the coronal suture. The wound edge is retracted and hemostasis is obtained with electrocautery. A cranial drill is used to make a single twist drill or burr hole 25-35 mm from the midline at the level of the coronal suture. The dura is coagulated and punctured. Next, components of the frame are assembled and coordinates set and the electrode guide is attached. The electrode array is marked for the appropriate depth of placement. The electrode array is passed into the pre-determined site using stereotactic coordinates. To establish a baseline, a neurologic examination is performed of relevant patient functions. The electrode array is inserted through the stereotactic guide and stimulated to determine the degree of tremor suppression. Microelectrode recording is not used during this phase of the procedure. The electrode array is repositioned and re-stimulated as many times as necessary to obtain the best degree of tremor suppression, reduced rigidity, limb mobility and coordination as well as possible side effects. When the position and clinical effect of stimulation appear optimal, absolute hemostasis is obtained and the electrode array is implanted, attaching the plastic ring and grommet to the burr hole in the skull. This procedure is usually monitored radiographically (fluoroscopic and/or x-ra, inherent/bundled) to assure that the electrode array has not changed position. The wounds are irrigated with antibiotic solution. If this is to be a one-stage operation (i.e., the stimulator generator is placed at the same operative setting), then the lead is coiled in a subgaleal pocket. The subgaleal and subcutaneous tissues are closed with interrupted 2-0 Vicryl suture. If this is to be a two-stage operation (i.e., the stimulator generator is placed at a later date), then the tail of the electrodes is subcutaneously tunneled and left in the subgaleal space. Either way, the subcutaneous tissues and skin are closed with deep sutures and staples. Sterile dressings are applied, and the stereotactic frame is removed. The four pin sites are dressed.

---

**SURVEY DATA**

<b>Presenter(s):</b>	Robert Florin, MD; Jeffrey Cozzens, MD				
<b>Specialty(s):</b>	American Society for Stereotactic and Functional Neurosurgery American Association of Neurological Surgeons/Congress of Neurological Surgeons				
<b>CPT Code:</b>	61864				
<b>Sample Size:</b>	130	<b>Resp n:</b>	36	<b>Resp %:</b>	28%
<b>Sample Type:</b>	Random - ASSFN; Random AANS subsection of stereotactic neurosurgery				
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		3.00	3.63	4.50	6.00
<b>Pre-Service Evaluation Time:</b>				0	
<b>Pre-Service Positioning Time:</b>				0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0	
<b>Intra-Service Time:</b>		45	60	68	90
<b>Post-Service</b>	<b>Total Min<sup>1</sup></b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	0				
<b>Critical Care time/visit(s):</b>	0				LOS = n/a
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	0				
<b>Office time/visit(s):</b>	0				

<sup>1</sup>Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
61864	<i>Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array</i>	Recom'd 4.50	ZZZ
63076	Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, each additional interspace (List separately in addition to code for primary procedure)	4.05	ZZZ

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

	Survey CPT 61864	Ref 63076 Hvd.
<b>TIME ESTIMATES (MEDIAN)</b>		
Pre-service	0	0
Intra-service	68	63
Same Day Immediate Post-service	0	0
Critical care	0	0
Other hospital visit	0	0
Discharge day management	0	0
Office visit	0	0
<b>TOTAL TIME</b>	68	63

**INTENSITY/COMPLEXITY MEASURES (mean)**

<b>Survey response count</b>	11	11
<b>TIME SEGMENTS</b>		
Pre-service	-	-
Intra-service	4.00	3.75
Post-service	-	-
<b>MENTAL EFFORT AND JUDGMENT</b>		
The number of possible diagnosis and/or the number of management options that must be considered	3.25	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	4.00
Urgency of medical decision making	3.00	3.00
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>		
Technical skill required	4.75	4.00
Physical effort required	3.50	3.75
<b>PSYCHOLOGICAL STRESS</b>		
The risk of significant complications, morbidity and/or mortality	4.50	4.00
Outcome depends on the skill and judgment of physician	5.00	4.50
Estimated risk of malpractice suit with poor outcome	4.00	4.00

**ADDITIONAL RATIONALE****Discussion of time and complexity/intensity comparison**

The time values from the survey have a good distribution and the survey median of 68 minutes appears reasonable for this procedure as it is an add-on to the base service 61863. Comparison to the time/motion study for cases without use of MER for the difference in time between the first and second side shows a difference of 52 minutes, which is reasonably close to the median of 68 minutes from these 36 respondents.

Comparing the time and intensity values to the reference code shows good conformity across both parameters.

The current median time and RVW produce an IWPUT of 0.066 which is reasonable for such an add-on code.

**Recommended RVW = 4.50**

### Services Reported with Multiple CPT Codes

1. Is this new/revised code typically reported on the same date with other CPT codes? Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes.

CPT	RVW					
	Glob	RVW	NS	Assistant	Neurology	Radiology
<b>61863:</b> Twist drill, ....., <b>without</b> use of intraoperative microelectrode recording; <b>first</b> array	90	19.00	19.00	3.04		
<b>61864:</b> Twist drill, ....., <b>without</b> use of intraoperative microelectrode recording; <b>second</b> array	ZZZ	4.50	4.50	0.72		
<b>95961:</b> Functional cortical and subcortical mapping by stim &/or recording of electrodes in brain, or depth electrodes, ... initial hour	XXX	2.97			2.97	
<b>95962:</b> Functional cortical and subcortical mapping by stim &/or recording of electrodes in brain, or depth electrodes, ... initial addl hour	XXX	3.21			3.21 x 2	
<b>70450:</b> CT, brain, w/o contrast	XXX	0.85				0.85
<b>70551:</b> Magnetic resonance imaging w/o contrast	XXX	1.48				1.48
<b>TOTAL RVW by Specialty</b>			<b>23.50</b>	<b>3.76</b>	<b>9.39</b>	<b>1.48</b>

CPT	TIME			
	NS	Asst	Neurology	Radiology
<b>61863:</b> Twist drill, ....., <b>without</b> use of intraoperative microelectrode recording; <b>first</b> array	429	140		
<b>61864:</b> Twist drill, ....., <b>without</b> use of intraoperative microelectrode recording; <b>second</b> array	68	68		
<b>95961:</b> Functional cortical and subcortical mapping by stim &/or recording of electrodes in brain, or depth electrodes, ... initial hour			65 ("pr")	
<b>95962:</b> Functional cortical and subcortical mapping by stim &/or recording of electrodes in brain, or depth electrodes, ... initial addl hour			140 ("pr")	
<b>70450:</b> CT, brain, w/o contrast				17 ("pr")
<b>70551:</b> Magnetic resonance imaging w/o contrast				28 ("pr")
<b>TOTAL RVW by Specialty</b>	<b>497</b>	<b>208</b>	<b>180</b>	<b>45</b>

**FREQUENCY INFORMATION****How was this service previously reported?**

61862-50 Twist drill, burr hole, craniotomy, or craniectomy for stereotactic implantation of one neurostimulator array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray) However, use of this code would be inaccurate since it was valued to include intraoperative microelectrode recording. Confusion arose because the CPT descriptor did not state this.

**How often do physicians in your specialty perform this service?**

Specialty: Neurosurgery                      ~~Commonly~~      Sometimes      Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Neurosurgery

Frequency: Unable to estimate

**For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?**

Specialty:      Neurosurgery

Frequency:      In 2001, there were 56 Medicare claims for 61862-51. This may have been a way to code for a second array, or this may represent multiple procedures. It is estimated that less than 5% of patients receiving 61863 will have add-on 61864.

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

---

CPT Code: 61867

Tracking No: EE3

Global: 090

Recommended RVW: ~~33.00~~

RUC Recommended: 31.34

**CPT Descriptor:** Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array

**Typical Patient:** A 66-year-old woman presents with a ten-year history of idiopathic Parkinson's disease that has caused progressive disability. She continues to respond to antiparkinson medications, however; her symptoms are no longer adequately controlled with medications and she is experiencing disability for many activities of daily living. Medication adjustments and different medication regimens have failed to improve her level of disability. She undergoes implantation of a stereotactically-guided deep brain stimulator electrode array in the subthalamic nucleus using microelectrode recording and macro stimulation for targeting and confirmation of electrode placement.

## CLINICAL DESCRIPTION OF SERVICE

### Description of Pre-Service Work:

Pre-service work includes review of records and any pertinent imaging studies; communicating with other professionals, patient, and family; and obtaining consent. The surgeon dresses for the procedure, and the patient's head is prepped for the procedure. The use of anti-Parkinson medications is stopped 24 hours before the procedure.

### Description of Intra-Service Work:

Prior to surgery, a local anesthetic is administered and a stereotactic frame is attached using pins to anchor the frame to the skull (inherent/bundled). Care is taken to align the frame with the inferior rim of the orbit and the external auditory meatus and to keep the frame level with the head. The surgeon accompanies the patient to the radiology department to obtain a CT or MRI scan (separately reportable with codes 70551 or 70450). The surgeon aligns the patient in the scanner. After the scans are performed, the surgeon plans the stereotactic surgery with computer assistance. This planning includes identifying MRI or CT marker points and the desired target; determining the coordinates for the target; measuring the AC-PC line; and calculating angles. Using a computer, various trajectories for the electrode placement to reach the target are examined before choosing one specific trajectory and calculating the entry point through the skull based upon safety and target coverage considerations using an anatomic atlas of the basal ganglia. After planning is complete, the patient returns to the OR and the surgeon helps position the patient on the operating table. While the patient is prepped and draped, the surgeon scrubs for the procedure.

Components of the frame are assembled, and the coordinates of the entry point are entered into the stereotactic arc system. The entry point is localized with the stereotactic arc and the incision is marked. Under IV sedation, the skin is infiltrated with local anesthetic. The previously marked incision is opened. The wound edge is retracted and hemostasis is obtained with electrocautery. A cranial drill is used to make a single twist drill or burr hole 25-35 mm from the midline at the level of the coronal suture. The dura is coagulated and punctured. The entry point of the guide cannula is inspected and the brain surface is coagulated, taking care to avoid major cortical vessels. Next, the electrode guide is attached to the stereotactic arc, and a guide cannula inserted into the brain. The microelectrode is tested for appropriate electrical impedance, placed into a second protective cannula, and attached to the microdrive. The microdrive/electrode assembly is then attached to the stereotactic arc, placing the inner protective cannula into the outer guide cannula. The microelectrode is then advanced using the microdrive, recording from individual neurons and pausing periodically to test the response of these neurons to light touch, passive joint movement, and other peripheral stimuli. The borders of the deep brain nuclei are mapped out and recorded in a linear format, referencing the electrophysiological findings to a stereotactic atlas. Microstimulation maybe periodically done during each microelectrode track, and the patient asked to report any side effects from the stimulation. Periodic examination of relevant neurologic functions and the effect of trial stimulation is performed by either the operating surgeon or a neurologist/ neurophysiologist. (Approximately half of the cases using MER will include a neurologist or neurophysiologist to work with the surgeon to achieve optimal targeting, separately reportable with codes 95961/95962). Numerous microelectrode tracks may be required to adequately define the target area. The average number of tracks is 2.4 for a unilateral procedure, which requires an average of 91 separate advances of the electrode by the microdrive.

Once an optimal target has been defined by microelectrode recording and stimulation, the microelectrode is removed from the outer cannula and the deep brain stimulation array is introduced. Test stimulation is carried out, testing for tremor suppression, reduced rigidity, limb mobility and coordination as well as possible side effects. The electrode array is repositioned and re-stimulated as many times as necessary to obtain the best degree of tremor suppression and least side effects. When optimal placement of the electrode is confirmed, the guide cannula is removed from the brain, leaving the electrode array in place. This procedure is usually monitored radiographically (fluoroscopic and/or x-ray, inherent/bundled) to assure that the electrode array has not changed position. The electrode array is fastened in place using an anchoring device. Absolute hemostasis is obtained. The lead is coiled in a subgaleal pocket. Galea is closed with sutures and the skin is closed with sutures or staples. Sterile dressings are applied, and the stereotactic frame is removed. The four pin sites are dressed.

#### Description of Post-Service Work:

Postoperative work includes communicating with the family and other health care professionals (including written and oral reports and orders); monitoring the patient's neurological condition for any deficits from either electrode placement and/or the stimulation itself; monitoring for wound infection; and antibiotic and pain medication management. Discharge day management includes the surgeon's final examination of the patient; review with the patient and family of post-discharge continuing care and instructions; resumption of the pre-surgical medications, and preparation of discharge records. Additionally, all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure; including removal of staples and sutures; monitoring wound healing; and examining the patient in the office at appropriate postoperative intervals to ensure adequate healing of all wounds.

#### SURVEY DATA

<b>Presenter(s):</b>	Robert Florin, MD; Jeffrey Cozzens, MD				
<b>Specialty(s):</b>	American Society for Stereotactic and Functional Neurosurgery American Association of Neurological Surgeons/Congress of Neurological Surgeons				
<b>CPT Code:</b>	61867				
<b>Sample Size:</b>	130	<b>Resp n:</b>	36	<b>Resp %:</b>	28%
<b>Sample Type:</b>	Random – ASSFN; Random AANS subsection of stereotactic neurosurgery				
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		23.00	27.63	28.80	33.00
<b>Pre-Service Evaluation Time:</b>				50	
<b>Pre-Service Positioning Time:</b>				15	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				15	
<b>Intra-Service Time:</b>		120	235	300	480
<b>Post-Service</b>	<b>Total Min<sup>1</sup></b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	30				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	79	99232 x 2; 99231 x 1			LOS =4
<b>Discharge Day Mgmt:</b>	36	99238			
<b>Office time/visit(s):</b>	69	99213 x 3			

<sup>1</sup>Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
61867	<i>Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording, first array</i>	Recom'd 33.00	090
61735	Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; subcortical structure(s) other than globus pallidus or thalamus	20.43	090

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

	Survey CPT 61867	Primary Ref 61735 HVD
<b>TIME ESTIMATES (MEDIAN)</b>		
Survey response count	36	--
Pre-service	80	39
Intra-service	300	184
Same Day Immediate Post-service	30	60
Critical care	0	131.8
Other hospital visit	79	
Discharge day management	36	
Office visit	69	52.5
<b>TOTAL TIME</b>	<b>594</b>	<b>467</b>

**INTENSITY/COMPLEXITY MEASURES (mean)**

Survey response count	11	11
<b>TIME SEGMENTS</b>		
Pre-service	4.36	4.18
Intra-service	4.91	4.18
Post-service	3.64	2.82
<b>MENTAL EFFORT AND JUDGMENT</b>		
The number of possible diagnosis and/or the number of management options that must be considered	4.45	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	4.55
Urgency of medical decision making	3.45	3.00
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>		
Technical skill required	4.91	4.18
Physical effort required	3.27	3.00
<b>PSYCHOLOGICAL STRESS</b>		
The risk of significant complications, morbidity and/or mortality	4.55	4.36
Outcome depends on the skill and judgment of physician	5.00	4.45
Estimated risk of malpractice suit with poor outcome	3.91	3.64

**ADDITIONAL RATIONALE**

*See Rationale for 61863*

**Services Reported with Multiple CPT Codes**

- Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions:

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

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

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

CPT	RVW					
	Glob	RVW	NS	Assistant	Neurology	Radiology
61867: Twist drill, ..., <b>with</b> use of intraoperative microelectrode recording; <b>first</b> array	90	33.00	33.00	5.28		
95961: Functional cortical and subcortical mapping by stim &/or recording of electrodes in brain, or depth electrodes, ... initial hour	XXX	2.97			2.97	
95962: Functional cortical and subcortical mapping by stim &/or recording of electrodes in brain, or depth electrodes, ... initial addl hour	XXX	3.21			3.21 x 2	
70450: CT, brain, w/o contrast	XXX	0.85				0.85
70551: Magnetic resonance imaging w/o contrast	XXX	1.48				1.48
<b>TOTAL RVW by Specialty</b>			<b>33.00</b>	<b>5.28</b>	<b>9.39</b>	<b>1.48</b>

CPT	TIME			
	NS	Asst	Neurology	Radiology
61867: Twist drill, ..., <b>with</b> use of intraoperative microelectrode recording; <b>first</b> array	429	300		
95961: Functional cortical and subcortical mapping by stim &/or recording of electrodes in brain, or depth electrodes, ... initial hour			65 ("pr")	
95962: Functional cortical and subcortical mapping by stim &/or recording of electrodes in brain, or depth electrodes, ... initial addl hour			140 ("pr")	
70450: CT, brain, w/o contrast				17 ("pr")
70551: Magnetic resonance imaging w/o contrast				28 ("pr")
<b>TOTAL RVW by Specialty</b>	<b>594</b>	<b>300</b>	<b>180</b>	<b>45</b>

**FREQUENCY INFORMATION****How was this service previously reported?**

61862 *Twist drill, burr hole, craniotomy, or craniectomy for stereotactic implantation of one neurostimulator array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray)*

However, use of this code would be inaccurate since it was valued to include intraoperative microelectrode recording. Confusion arose because the descriptor did not state this.

**How often do physicians in your specialty perform this service?**

Specialty: Neurosurgery                      ~~Commonly~~      Sometimes      Rarely

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Neurosurgery

Frequency: Medicare utilization data shows a utilization for 2001 of 860 cases. However, many of these procedures are done on patients under 65 years. The exact number is not known.

**For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?**

Specialty: Neurosurgery

Frequency: In 2001, there were 860 Medicare claims for 61862 (no modifier). It is estimated that the split of 61862 into 61863 and 61867 will be 40% to 60%.

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

---

---

**CPT Code:** 61868      **Tracking No:** EE4      **Global:** ZZZ      **Recommended RVW:** ~~8.00~~  
**RUC Recommended RVW:** 7.92

**CPT Descriptor:** Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; each additional array

---

**Typical Patient:** A 66-year-old woman presents with a ten-year history of idiopathic Parkinson's disease that has caused progressive disability. She continues to respond to antiparkinson medications, however; her symptoms are no longer adequately controlled with medications and she is experiencing disability for many activities of daily living. Medication adjustments and different medication regimens have failed to improve her level of disability. She undergoes implantation of a second stereotactically-guided deep brain stimulator electrode array in the subthalamic nucleus using microelectrode recording and macro stimulation for targeting and confirmation of electrode placement bilaterally. [Note: only consider the "additional" work related to implantation of a second array.]

---

## CLINICAL DESCRIPTION OF SERVICE

### Description of Intra-Service Work:

After the scans are performed, the surgeon plans the stereotactic surgery with computer assistance. This planning includes identifying MRI or CT marker points bilaterally and the desired targets on the second side; determining the coordinates for the targets; measuring the AC-PC line; and calculating angles. Using a computer, various trajectories for the electrode placement to reach the targets are examined before choosing one specific trajectory and calculating the entry point through the skull based upon safety and target coverage considerations using an anatomic atlas of the basal ganglia. After implantation of the first electrode array, the scalp is re-prepped and draped for the second electrode implantation and the surgeon scrubs.

The coordinates of the entry point for the second side are entered into the stereotactic arc system. The entry point for the second implant is localized with the stereotactic arc and the incision site is marked. Under IV sedation, the skin is infiltrated with local anesthetic. The marked incision site is opened. The wound edge is retracted and hemostasis is obtained with electrocautery. A cranial drill is used to make a single twist drill or burr hole at the calculated entry site, which is usually 25-35 mm from the midline at the level of the coronal suture. The dura is coagulated and punctured. The entry point of the guide cannula is inspected and the brain surface is coagulated, taking care to avoid major cortical vessels. Next, the electrode guide is attached to the stereotactic arc, and a guide cannula inserted into the brain. The microelectrode is tested for appropriate electrical impedance, withdrawn into a second protective cannula, and attached to the microdrive. The microdrive/electrode assembly is then attached to the stereotactic arc, placing the inner protective cannula into the outer guide cannula. The microelectrode is then advanced using the microdrive, recording from individual neurons and pausing periodically to test the response of these neurons to light touch, passive joint movement, and other stimuli. The borders of the deep brain nuclei are mapped out and recorded in a linear format, referencing the electrophysiological findings to a stereotactic atlas. Microstimulation may be periodically carried out during each microelectrode track, and the patient is asked to report any side effects from stimulation. Periodic examination of relevant neurologic functions and the effect of trial stimulation is performed by either the operating surgeon or a neurologist/ neurophysiologist. (Approximately half of the cases using MER will include a neurologist or neurophysiologist to work with the surgeon to achieve optimal targeting, separately reportable with codes 95961/95962). Numerous microelectrode tracks may be required to adequately define the target area. The average number of tracks is 2.1 for the second implantation, which requires an average of 92 separate advances of the electrode by the microdrive.

Once an optimal target has been defined by microelectrode recording and stimulation, the microelectrode is removed from the outer cannula and the deep brain stimulation array is introduced. Test stimulation is carried out, testing for tremor suppression, reduced rigidity, limb mobility and coordination as well as possible side effects. The electrode array is repositioned and re-stimulated as many times as necessary to obtain the best degree of tremor suppression and least side effects. The guide cannula is removed from the brain, leaving the electrode array in place. This procedure is usually monitored radiographically (fluoroscopic and/or x-ray, inherent/bundled) to assure that the electrode array has not changed position. The electrode array is fastened in place using an anchoring device. Absolute hemostasis is obtained. The lead is coiled in a subgaleal pocket. Galea is closed with sutures and the skin is closed with sutures or staples. Sterile dressings are applied, and the stereotactic frame is removed. The four pin sites are dressed.

### SURVEY DATA

<b>Presenter(s):</b>	Robert Florin, MD; Jeffrey Cozzens, MD				
<b>Specialty(s):</b>	American Society for Stereotactic and Functional Neurosurgery American Association of Neurological Surgeons/Congress of Neurological Surgeons				
<b>CPT Code:</b>	61868				
<b>Sample Size:</b>	130	<b>Resp n:</b>	36	<b>Resp %:</b>	28%
<b>Sample Type:</b>	Random - ASSFN; Random AANS subsection of stereotactic neurosurgery				
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		5.00	6.00	7.00	8.00
<b>Pre-Service Evaluation Time:</b>				0	
<b>Pre-Service Positioning Time:</b>				0	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0	
<b>Intra-Service Time:</b>		60	119	120	180
<b>Post-Service</b>	<b>Total Min<sup>1</sup></b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	0				
<b>Critical Care time/visit(s):</b>	0				LOS = n/a
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	0				
<b>Office time/visit(s):</b>	0				

<sup>1</sup>Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
61868	<i>Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; each additional array</i>	<i>Recom'd 8.00</i>	<i>ZZZ</i>
63076	Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, each additional interspace (List separately in addition to code for primary procedure)	4.05	ZZZ

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

	Survey CPT 61868	Ref 63076 Hvd.
<b>TIME ESTIMATES (MEDIAN)</b>		
Pre-service	0	0
Intra-service	120	63
Same Day Immediate Post-service	0	0
Critical care	0	0
Other hospital visit	0	0
Discharge day management	0	0
Office visit	0	0
<i>TOTAL TIME</i>	<i>120</i>	<i>63</i>

**INTENSITY/COMPLEXITY MEASURES (mean)**

Survey response count	10	10
<b>TIME SEGMENTS</b>		
Pre-service	-	-
Intra-service	4.25	3.75
Post-service	-	-
<b>MENTAL EFFORT AND JUDGMENT</b>		
The number of possible diagnosis and/or the number of management options that must be considered	3.25	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	4.00
Urgency of medical decision making	3.00	3.00
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>		
Technical skill required	5.00	4.00
Physical effort required	3.75	3.75
<b>PSYCHOLOGICAL STRESS</b>		
The risk of significant complications, morbidity and/or mortality	4.50	4.00
Outcome depends on the skill and judgment of physician	5.00	4.50
Estimated risk of malpractice suit with poor outcome	4.00	4.00

**ADDITIONAL RATIONALE**

The survey time values for this code are remarkably uniform from the 25<sup>th</sup> to the 75<sup>th</sup> percentile, indicating that the majority of respondents agreed on the median time very well at 120 minutes. This time is almost twice that of the reference code at 63 minutes.

The intensity survey data indicate that this code exceeds the intensity of the reference code for almost all the categories. The increased time and higher intensity support a value for 61868 of approximately twice that of 63076, the reference service at 4.05.

When a work RVU of 7.00 is used, the IWPUT for this code is 0.058. This is significantly lower than the IWPUT for 61863 which is the inverse of what that relationship should be at face value. This corrects when the survey 75<sup>th</sup> percentile value of 8.00 RVUs is used, with the new IWPUT at 0.067.

**Recommended work RVU : 8.00**

**Services Reported with Multiple CPT Codes**

1. Is this new/revised code typically reported on the same date with other CPT codes? Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

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

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes.

CPT	RVW					
	Glob	RVW	NS	Assistant	Neurology	Radiology
<b>61867:</b> Twist drill, ....., <b>with</b> use of intraoperative microelectrode recording; <b>first</b> array	90	33.00	33.00	5.28		
<b>61868:</b> Twist drill, ....., <b>with</b> use of intraoperative microelectrode recording; <b>second</b> array			8.00	1.28		
<b>95961:</b> Functional cortical and subcortical mapping by stim &/or recording of electrodes in brain, or depth electrodes, ... initial hour	XXX	2.97			2.97	
<b>95962:</b> Functional cortical and subcortical mapping by stim &/or recording of electrodes in brain, or depth electrodes, ... initial addl hour	XXX	3.21			3.21 x 2	
<b>70450:</b> CT, brain, w/o contrast	XXX	0.85				0.85
<b>70551:</b> Magnetic resonance imaging w/o contrast	XXX	1.48				1.48
<b>TOTAL RVW by Specialty</b>			<b>41.00</b>	<b>6.56</b>	<b>9.39</b>	<b>1.48</b>

CPT	TIME			
	NS	Asst	Neurology	Radiology
<b>61867:</b> Twist drill, ....., <b>with</b> use of intraoperative microelectrode recording; <b>first</b> array	429	300		
<b>61868:</b> Twist drill, ....., <b>with</b> use of intraoperative microelectrode recording; <b>second</b> array	120	120		
<b>95961:</b> Functional cortical and subcortical mapping by stim &/or recording of electrodes in brain, or depth electrodes, ... initial hour			65 ("pr")	
<b>95962:</b> Functional cortical and subcortical mapping by stim &/or recording of electrodes in brain, or depth electrodes, ... initial addl hour			140 ("pr")	
<b>70450:</b> CT, brain, w/o contrast				17 ("pr")
<b>70551:</b> Magnetic resonance imaging w/o contrast				28 ("pr")
<b>TOTAL RVW by Specialty</b>	<b>549</b>	<b>420</b>	<b>180</b>	<b>45</b>

**FREQUENCY INFORMATION**

**How was this service previously reported?**

61862-50 Twist drill, burr hole, craniotomy, or craniectomy for stereotactic implantation of one neurostimulator array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray) However, use of this code would be inaccurate since it was valued to include intraoperative microelectrode recording. Confusion arose because the CPT descriptor did not state this.

**How often do physicians in your specialty perform this service?**

Specialty: Neurosurgery                      ~~Commonly~~      Sometimes      ~~Rarely~~

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty: Neurosurgery

Frequency: Unable to estimate

**For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?**

Specialty:        Neurosurgery

Frequency:        In 2001, there were 56 Medicare claims for 61862-51. This may have been a way to code for a second array, or this may represent multiple procedures. It is estimated that less than 5% of patients receiving 61867 will have add-on 61868.

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

---

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
090 Day Global Period  
Facility Direct Inputs**

<b>CPT</b>	<b>DESCRIPTION</b>	<b>GLOBAL</b>
<b>61863</b>	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), <u>without</u> use of intraoperative microelectrode recording; first array	<b>90</b>
<b>61864</b>	each additional array	<b>ZZZ</b>
<b>61867</b>	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), <u>with</u> use of intraoperative microelectrode recording; first array	<b>90</b>
<b>61868</b>	each additional array	<b>ZZZ</b>

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:** The direct practice expense inputs were crosswalked from previously PEAC-approved details for the neurosurgery family of codes for twist drill/burr hole procedures. For additional supply items, see attached RUC approved "standard" neurosurgery post-operative incision care kit.

**CLINICAL STAFF TYPE:**

RN/LPN/MA 1130

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time (prior to admission):** For each of these 90-day facility only procedures, the standard "typical" 60 minutes have been applied to X1 and X3.

**Service period clinical staff time (admission to discharge):**

Pre-service: N/A

Intra-service: N/A

Post-service: 12 minutes of clinical staff time for work related to facility discharge (99238 level) for X1 and X3

**Post-service period clinical staff time:** Standard EM postop visit time for clinical staff has been applied for each office visit for X1 and X3

**SUPPLIES AND EQUIPMENT:**

Minimum visit package (multispecialty) for each post-op visit.

Post-op incision care kit at first post-op visit.

Suture removal kit at first post-op visit.

Patient education booklet on day of discharge.

**SUPPLIES AND EQUIPMENT:**

Power table and exam lamp for post-op visits.

**RUC APPROVED STANDARD SUPPLY PACKAGE (2002):**

**PEAC Pack compared with the NS Standard Post-Op Incision Care Kit**

<u>Code</u>	<u>Description</u>	<u>Unit</u>	<u>PEAC post-op pack</u>	<u>Standard</u>	<u>Craniotomy</u>	<u>Spine</u>	<u>Periph Nerv</u>
14005	Gloves, sterile	pair	1	1	1	1	1
11302	Swab, alcohol	item	2	2	2	2	2
31505	Gauze, Sterile 4 x 4	item	2	2	4	4	2
31513	Steri-strips	strip	12	12	12	12	12
31514	Tape	inch	12	12	60	36	18
31702	Staple removal kit	item	1	1	1	1	1
52301	Betadine	ml	20	20	20	20	20
52308	Tincture benzoin swab	item	1	1	2	2	1
31703	Suture removal kit	item	0	1-0*	1	1	0
31509	Kling roller bandage 2 x 131	item	0	0	1	0	1

\*Additional Quantities or Items not included in PEAC post-op incision care kit added to attached excel file.

6186X1-6186X4 PE Details (April 2003 RUC)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	61863		61864	
		Twist drill, burr hole, craniotomy; or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array		Twist drill, burr hole, craniotomy; or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording, each additional array	
GLOBAL PERIOD		90		ZZZ	
LOCATION		NonFac	Fac	NonFac	Fac
<b>TOTAL CLINICAL LABOR TIME</b>	1130	N/A	180.0	N/A	0.0
<b>PRE-SERVICE PERIOD TOTAL TIME</b>	1130		60.0		0.0
<b>SERVICE PERIOD TOTAL TIME</b>	1130		12.0		0.0
<b>POST-SERVICE PERIOD TIME</b>	1130		108.0		0.0
<b>PRE-SERVICE PERIOD</b>					
Complete pre-service diagnostic & referral forms	1130		5		
Coordinate pre-surgery services	1130		20		
Schedule space and equipment in facility	1130		8		
Provide pre-service education/obtain consent	1130		20		
Follow-up phone calls & prescriptions	1130		7		
Other Clinical Activity (please specify)					
<b>SERVICE PERIOD</b>					
<b>Pre-service</b>			0		
<b>Intra-service</b>			0		
<b>Post-Service</b>					
Discharge day management 99238 –12 minutes 99239 –15 minutes	1130		12		
Other Clinical Activity (please specify)					
<b>POST-SERVICE PERIOD</b>					
Conduct phone calls/call in prescriptions					
<i>List Number and Level of Office Visits</i>					
99211 16 minutes					
99212 27 minutes					
99213 36 minutes			3		
99214 53 minutes					
99215 63 minutes					
<b>Total Office Visit Time</b>	1130	0	108	0	0
Other Activity (please specify)					
<b>MEDICAL SUPPLIES</b>					
minimum visit package (multispecialty)	PEAC pack		3		
post-op incision care kit	PEAC kit		1		
<b>Additional incision care supplies:</b>					
suture removal kit	31703		1		
<b>Equipment</b>					
power table	E11003		1		
exam lamp	E30006		1		

6186X1-6186X4 PE Details (April 2003 RUC)	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	61867		61868	
		Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, peraqueductal gray), with use of intraoperative microelectrode recording, first array		Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, peraqueductal gray), with use of intraoperative microelectrode recording; each additional array	
GLOBAL PERIOD		90		ZZZ	
LOCATION		NonFac	Fac	NonFac	Fac
TOTAL CLINICAL LABOR TIME	1130	N/A	180.0	N/A	0.0
PRE-SERVICE PERIOD TOTAL TIME	1130		60.0		0.0
SERVICE PERIOD TOTAL TIME	1130		12.0		0.0
POST-SERVICE PERIOD TIME	1130		108.0		0.0
<b>PRE-SERVICE PERIOD</b>					
Complete pre-service diagnostic & referral forms	1130		5		
Coordinate pre-surgery services	1130		20		
Schedule space and equipment in facility	1130		8		
Provide pre-service education/obtain consent	1130		20		
Follow-up phone calls & prescriptions	1130		7		
Other Clinical Activity (please specify)					
<b>SERVICE PERIOD</b>					
Pre-service			0		
Intra-service			0		
Post-Service					
Discharge day management 99238 --12 minutes 99239 --15 minutes	1130		12		
Other Clinical Activity (please specify)					
<b>POST-SERVICE PERIOD</b>					
Conduct phone calls/call in prescriptions					
<i>List Number and Level of Office Visits</i>					
99211 16 minutes					
99212 27 minutes					
99213 36 minutes			3		
99214 53 minutes					
99215 63 minutes					
<b>Total Office Visit Time</b>	1130	0	108	0	0
Other Activity (please specify)					
<b>MEDICAL SUPPLIES</b>					
minimum visit package (multispecialty)	PEAC pack		3		
post-op incision care kit	PEAC kit		1		
<b>Additional incision care supplies:</b>					
suture removal kit	31703		1		
<b>Equipment</b>					
power table	E11003		1		
exam lamp	E30006		1		

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Lumbar and Superior Hypogastric Plexus Injection and Destruction**

CPT created three new codes and revised an existing code to describe superior hypogastric plexus blocks since they require a technique substantially different from other blocks, and existing nerve block codes do not accurately describe this service.

**64449**

The RUC examined survey data for code 64449, *Injection, anesthetic agent; lumbar plexus, posterior approach continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration*, in relation to other codes in the family. The presenters explained that the survey respondents underestimated the intra-service time, since this is not a widely performed procedure. To prevent creating a rank order anomaly, the RUC identified CPT code 64448, *Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration*, as a reference code for physician work. In comparison to code 64448 (intra-service time of 25 minutes), the new code should have similar intra-service time. Therefore, the RUC recommends intra-service time of 25 minutes. Also, the RUC determined that a work RVU of 3.0 would place the code in proper rank order relative to the family. The RUC also examined code 64483, *Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level* (000-day global period, work RVU = 1.90), to provide additional support for an RVU of 3.00 and used the following building block comparison:

64483	1.90 RVU
<u>99231x2=</u>	<u>1.28 RVU</u>
	3.18 RVU

The RUC felt that 64483 plus two hospital visits had similar physician work to 64449.

Also, the recommended value of 3.00 lies between the 25<sup>th</sup> percentile and median survey values. The RUC is aware that two post-operative hospital visits identified through the survey are lower than the three post-operative visits that are included in the family of similar codes, yet the committee was not comfortable changing survey data.

**The RUC recommends a work RVU of 3.00 for CPT code 64449 and 25 minutes of intra-service time.**

### **64517**

The RUC reviewed code 64517 *Injection, anesthetic agent; superior hypogastric plexus* which is typically used in cancer patients for pain relief. In comparison to the reference codes the RUC concluded that the higher intensity measure supported a RVU greater than the reference services 64520 *Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)* (work RVU = 1.35) and 64530 *Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring* (work RVU= 1.58) and supported the median RVU of 2.20. The main differences among this code and the reference services in the intra-service intensity and complexity due to the difficulty in positioning and administering the block due to the anatomical area where this is performed.

**The RUC recommends a work RVU of 2.20 for CPT code 64517.**

### **64681**

The RUC reviewed the survey results, and agreed that the respondents appropriately rated the new service as more intense and complex and as requiring more pre- and post-service time compared to the reference services 64622 *Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level* (work RVU, 3.00) and 64680 *Destruction by neurolytic agent, celiac plexus, with or without radiologic monitoring* (work RVU, 2.62). Additionally, a review of the RVUs of other injections listed in the reference service list illustrates that the recommended work RVU correctly rank orders the new code. A neurolytic trigeminal nerve block (CPT 64600) has 3.45 work RVUs. These are much simpler than a neurolytic hypogastric plexus block. In addition, a continuous brachial plexus block (CPT 64416) - a nerve block with a 10 day global period - has 3.50 work RVUs. A trigeminal nerve destruction of foramen ovale (CPT 64610) is valued at 7.16 RVUs. This code is similar to 64517 except that instead of injecting an anesthetic agent, this code involves a neurolytic agent. Typically, the patient is in the hospital and the anesthesiologist performs the procedure and also performs two follow-up hospital visits, but does not have any discharge day management work. This procedure can also be performed in the office, but most of these procedures are performed in the hospital setting in large cancer centers. The RUC concluded that the survey data supported the median RVU of 3.55.

**The RUC recommends a work RVU of 3.55 for CPT code 64681.**

### **Practice Expense**

The RUC determined that the standard pre-service times are applicable, however for 64449 and 64681, zero pre-service time in the facility setting was assigned since the patient is typically an inpatient and the hospital staff perform the pre-service work, not the physician's office staff. Also, the assist physician time was assigned at 100% of physician intra-service time. For code 64681, 2 office visits are assigned to the non-facility setting since when it is performed in this setting there are 2 office visits instead of the 2 hospital visits.

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

CPT Code (●New)	Track ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●64449	FF1	Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration  (Do not report 01996 in addition to 64449)  (Do not report 64520 in addition to 64449)	010	3.00
●64517	FF2	Injection, anesthetic agent; superior hypogastric plexus	000	2.20
▲64680		Destruction by neurolytic agent, <del>celiac</del> plexus, with or without radiologic monitoring; <u>celiac</u> <u>plexus</u>	010	2.62 (no change)
●64681	FF3	superior hypogastric plexus	010	3.55

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

---

CPT Code: 64449    Tracking Number: FF1    Global Period: 010    Recommended RVW: ~~3-15~~ 3.00

CPT Descriptor: Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration  
(Do not report 01996 in addition to 6444X)

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** A 62-year-old female undergoes a left total knee replacement (CPT code 27447) under general anesthesia. In order to provide post-operative pain control and increased mobility in her knee, earlier ambulation, and enhanced rehabilitation, a continuous lumbar plexus block (psoas compartment block) is performed.

**Percentage of Survey Respondents who found Vignette to be Typical: 96%**

Respondents who felt that their typical patient differed from the one on the survey described patients with acetabular fractures. It was also noted that this could be performed for a chronic pain patient, not just a surgical patient.

**Description of Pre-Service Work:**

- History, physical, laboratory review focusing on relative and absolute contraindications to the procedure (infection, coagulopathy, neural deficits, anatomic abnormalities, etc)
- Informed consent

**Description of Intra-Service Work:** When placing a left lumbar plexus block, the patient is placed in the right lateral decubitus position with the thighs and knees flexed. Blood pressure cuff, pulse oximeter and electrocardiographic monitors are applied. After an intravenous infusion is initiated and supplemental oxygen is provided, intravenous anxiolytics and analgesics are administered. The left low back is prepped with a topical antiseptic. A line is drawn between the iliac crests, i.e., Tuffier's line. A second line is made 3-5 cm parasagittally to the left. A mark for the needle insertion is made where the two lines intersect. After infiltrating the skin and deeper tissues with local anesthetic, a 19-gauge, 10 cm needle, designed to allow the introduction of a catheter through the needle and connected to a peripheral nerve stimulator, is advanced to obtain stimulation of the lumbar plexus. When a transverse process is encountered, the needle is then partially withdrawn and advanced slightly cephalad until it slides past the transverse process of the lumbar vertebra.

When the needle tip is in the psoas compartment and in the proper location, stimulation of the lumbar plexus is recognized by observing the rise of patella, contraction of the quadriceps and sartorius muscles. Generally current of 0.6 to 0.8 mA indicate stimulation of the femoral nerve when the needle is correctly positioned.

At this point careful aspiration for blood and CSF is performed. A test dose of local anesthetic (3 ml of 2% lidocaine with epinephrine 1:200,000) is administered to rule out IV or intrathecal injection. Between 15 and 30 ml of dilute local anesthetic (e.g., 0.25% bupivacaine, 0.2% ropivacaine) is slowly injected through the needle, followed by insertion of an infusion catheter through the needle (about 5 cm past the tip of the needle). The patient is observed for signs of undesired epidural spread and associated hemodynamic changes, and for analgesia of the left leg and hip. The catheter is checked for intravascular and intrathecal placement and secured in place. Once correct function of the catheter is confirmed, a continuous infusion of dilute concentration of local anesthetic (e.g., 0.2% ropivacaine, 0.25 % bupivacaine) is started at 8-10 ml/hour. Alternatively, a patient controlled infusion may be started at 5 ml/hr with a bolus of 10 ml/30-60 minutes. Assistance at the time of ambulation is essential.

The complications of a lumbar plexus block include: intravascular injection:intrathecal injection with high level of the resultant spinal block, infection, ureteral, venous, or renal puncture; intraperitoneal injection; hematoma of the psoas muscle with nerve compression; and extension of anesthesia into the epidural space.

**Description of Post-Service Work:**

- Re-evaluate efficacy and function of block
- Adjust infusion as clinically indicated
- Infusion typically continues for several days
- Examine for local infection, bleeding, or other complications
- Document findings

**SURVEY DATA**

<b>Presenter(s):</b>	James D. Grant, M.D., Eduardo M. Fraifeld, M.D.				
<b>Specialty(s):</b>	American Society of Anesthesiologists, American Academy of Pain Medicine				
<b>CPT Code:</b>	64449				
<b>Sample Size:</b> 320	<b>Resp n:</b> 49	<b>Resp %:</b> 15%			
<b>Sample Type:</b> Panel					
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	2.00	2.50	3.15	3.50	5.00
<b>Pre-Service Evaluation Time:</b>	5	10	10	15	30
<b>Pre-Service Positioning Time:</b>	5	5	10	10	25
<b>Pre-Service Scrub, Dress, Wait Time:</b>	0	5	5	10	20
<b>Intra-Service Time:</b>	5	10	15 25	25	60
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	20				
<b>Critical Care time/visit(s):</b>					
<b>Other Hospital time/visit(s):</b>	38	99231 x 2			
<b>Discharge Day Mgmt:</b>					
<b>Office time/visit(s):</b>					

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
64416	Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration (Do not report 01996 in addition to 64416)	010	3.50
64446	Injection, anesthetic agent; sciatic nerve , continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration (Do not report 01996 in addition to 64446)	010	3.25

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

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

Number of respondents who choose Key Reference Code: Code 64416 21  
Code 64446 17

**TIME ESTIMATES (Median)**

	New/Revis. CPT Code 6444X	Key Reference CPT Code 64416 (from 4/2002 Work Summary)	Key Reference CPT Code 64446 (from 4/2002 Work Summary)
Median Pre-Service Time	25	30	15
Median Intra-Service Time	25	30	27.5
Median Immediate Post-service Time	20	20	15
Median Critical Care Time			
Median Other Hospital Visit Time	38	57	57
Median Discharge Day Management Time			
Median Office Visit Time			
Median Total Time	108	137	114.5

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

	New/Revis. CPT Code 6444X	Key Reference CPT Code 64416	New/Revis. CPT Code 6444X	Key Reference CPT Code 64446
The number of possible diagnosis and/or the number of management options that must be considered	3.19	3.14	3.17	2.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.29	3.05	3.00	3.00
Urgency of medical decision making	3.33	3.14	2.89	2.89

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.81	3.81	3.33	3.67
Physical effort required	3.52	3.33	2.78	3.11
<b>Psychological Stress (Mean)</b>				
The risk of significant complications, morbidity and/or mortality	3.52	3.43	3.00	3.28
Outcome depends on the skill and judgement of physician	3.86	3.71	3.67	3.78
Estimated risk of malpractice suit with poor outcome	3.48	3.67	3.28	3.22

**INTENSITY/COMPLEXITY MEASURES**

<b>CPT Code 6444X</b>	<b>Reference Service 64416</b>	<b>CPT Code 6444X</b>	<b>Reference Service 64446</b>
---------------------------	--	---------------------------	--

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.24	3.05	3.06	2.94
Intra-Service intensity/complexity	3.62	3.48	3.50	3.44
Post-Service intensity/complexity	3.14	3.00	3.17	3.06



**ADDITIONAL RATIONALE**

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

We noted that there was a high level of confidence in the vignette. The intensity/complexity values for the new service were quite similar to those for the reference services. We conclude that 3.15 work RVUs (the survey mean and median) is an accurate valuation for this service.

**IWPUT Calculation:**

<b>Pre-Service</b>						
	<b>Minutes</b>	<b>Intensity</b>	<b>RVU's</b>			
<b>Day Prior</b>	10	0.0224	0.22			
<b>Immediate Pre</b>	10	0.0224	0.22			
<b>Scrub, prep</b>	5	0.0081	0.04			
<b>Pre-Service Total</b>			0.49			
<b>Immediate Post</b>	20	0.0224	0.45			
	<b># Visits</b>	<b>Discounted RVU</b>	<b>Total RVU</b>	<b>Total Time</b>	<b>Face Time</b>	<b>Total Visit Time</b>
<b>Post-service Hospital Visits</b>						
99231	2	0.64	1.28	19	15	38
99232		1.06	0.00	30	25	0
99233		1.51	0.00	41	35	0
<b>Critical Care</b>						
99291		4.00	0.00	63		0
99292		2.00	0.00	32		0
99296		16.00	0.00	126		0
99297		8.00	0.00	64		0
<b>Discharge Planning</b>						
99238		1.28	0.00	36		0
99239		1.75	0.00	45		0
<b>Office Visits</b>						
99211		0.17	0.00	7	5	0
99212		0.43	0.00	15	10	0
99213		0.65	0.00	23	15	0
99214		1.08	0.00	38	25	0
99215		1.73	0.00	59	40	0
<b>Subsequent Visits</b>	2		1.28		Post Post Discharge	38 0
<b>Post-Service Total</b>			1.73		Total Time	98
<b>Intraservice Time</b>	15					
<b>Intraservice Work</b>	0.93					
<b>IWPUT</b>	<b>0.062</b>					

## SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

---

---

## FREQUENCY INFORMATION

How was this service previously reported? 64450, 62319, 64448 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Anesthesiology  Commonly  Sometimes  Rarely

Specialty AAPM  Commonly  Sometimes  Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Estimated use is 5,000 to 10,000 times per year. Predominately used for post-operative pain control and for operative anesthesia

Specialty Anesthesiology Frequency 4,000 - 8,000

Specialty AAPM Frequency 1,000 - 2,000

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

Specialty Anesthesiology Frequency 2,700 - 5,400

Specialty AAPM Frequency 650 - 1,300

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

---

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

---

CPT Code: 64517 Tracking Number: FF2 Global Period: 000 Recommended RVW: 2.20

CPT Descriptor: Injection, anesthetic agent; superior hypogastric plexus

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** A 75-year old male with known prostatic carcinoma and pelvic metastases is suffering from intractable pelvic pain with severe spasms and cramps. Oral medications have not helped him. The patient has been referred to an interventional pain specialist for a superior hypogastric plexus block to relieve his intractable pelvic pain.

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

Respondents noted that the typical patient could also be one with chronic non-malignant pain or a female with pelvic pain.

**Description of Pre-Service Work:**

- Focused history, physical, laboratory review to evaluate for infection and coagulopathy
- Review of old medical records
- Informed consent
- Intravenous access obtained (if clinically indicated)

**Description of Intra-Service Work:** The patient is taken to the operating room or procedure suite. He is placed in the prone position. EKG, blood pressure and pulse oximetry are applied. His back is prepared with Betadine. A #22 gauge 6 inch short beveled spinal needle is inserted bilaterally to the anterolateral spine at the L5-S1 interspace. Proper needle location is determined, employing radiological imaging guidance (reported separately). Radiographic contrast is then injected demonstrating flow in the pre-vertebral space, anterior to the psoas muscle fascia. After careful negative aspiration for blood, urine and CSF, 6 cc of local anesthetic is injected on each side. The patient is then transferred to the recovery room where he is carefully observed and monitored for early signs of complications.

The complications of the procedure include puncture of the iliac vessels and bleeding, intravascular injection of local anesthetics -- with possible seizures or cardiovascular collapse, nerve injury to the cauda equina, or exiting spinal nerves, puncture of the ureters and other pelvic viscera. Infection is always a possibility, especially in immuno-suppressed cancer patients.

**Description of Post-Service Work:**

- Procedure note dictation
  - Post-procedure orders
  - Pre-discharge evaluation
  - Discharge planning
  - Discussion of procedure findings and implications for additional care
-

**SURVEY DATA**

<b>Presenter(s):</b>		James. D. Grant, M.D., Eduardo M. Fraifeld, M.D.				
<b>Specialty(s):</b>		American Society of Anesthesiology, American Academy of Pain Medicine				
<b>CPT Code:</b>		64517				
<b>Sample Size:</b>	320	<b>Resp n:</b>	47	<b>Resp %:</b>	15%	
<b>Sample Type:</b> Panel						
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		1.35	2.00	2.20	2.50	3.80
<b>Pre-Service Evaluation Time:</b>		2	10	10	15	45
<b>Pre-Service Positioning Time:</b>		3	5	10	10	25
<b>Pre-Service Scrub, Dress, Wait Time:</b>		3	5	10	10	20
<b>Intra-Service Time:</b>		5	18	25	30	60
<b>Post-Service</b>		<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>		<u>20</u>				
<b>Critical Care time/visit(s):</b>						
<b>Other Hospital time/visit(s):</b>						
<b>Discharge Day Mgmt:</b>						
<b>Office time/visit(s):</b>						

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)	000	1.35
64530	Injection, anesthetic agent; celiac plexus with or without radiological monitoring	000	1.58

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

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

Number of respondents who choose Key Reference Code: Code 64520 24  
Code 64530 18

**TIME ESTIMATES (Median)**

	New/Revis. CPT Code 645X1	Key Reference CPT Code: 64520	Key Reference CPT Code: 64530
Median Pre-Service Time	30	11 (Harvard)	Not Available
Median Intra-Service Time	25	24 (Harvard)	Not Available
Median Immediate Post-service Time	20	11 (Harvard)	Not Available
Median Critical Care Time			
Median Other Hospital Visit Time			
Median Discharge Day Management Time			
Median Office Visit Time			
Median Total Time	75	46	49

**INTENSITY/COMPLEXITY MEASURES (Mean)**

<b><u>Mental Effort and Judgement (Mean)</u></b>	New/Revis. CPT Code 645X1	Key Reference CPT Code: 64520	New/Revis. CPT Code 645X1	Key Reference CPT Code: 64530
The number of possible diagnosis and/or the number of management options that must be considered	3.83	3.00	3.88	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.87	3.04	4.12	3.94
Urgency of medical decision making	3.79	3.13	3.56	3.50

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.88	3.17	4.67	4.33
Physical effort required	3.79	3.13	4.06	3.72

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.88	3.04	4.28	4.22
Outcome depends on the skill and judgement of physician	3.96	3.21	4.50	4.28
Estimated risk of malpractice suit with poor outcome	3.79	3.04	4.28	4.06

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code  
645X1**

**Reference  
Service  
64520**

**CPT Code  
645X1**

**Reference  
Service  
64530**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.58	2.96	3.67	3.56
Intra-Service intensity/complexity	3.88	3.25	4.56	4.28
Post-Service intensity/complexity	3.67	3.00	3.56	3.56

---

**ADDITIONAL RATIONALE**

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

The survey results yielded higher work estimates, higher time measurements compared to reference code 64520, and higher intensity/complexity measurements compared to both reference services. We agree with the survey results and recommend at work RVU of 2.20.

**IWPUT Calculation:**

<b>Pre-Service</b>						
	<b>Minutes</b>	<b>Intensity</b>	<b>RVU's</b>			
<b>Day Prior</b>	10	0.0224	0.22			
<b>Immediate Pre</b>	10	0.0224	0.22			
<b>Scrub, prep</b>	10	0.0081	0.08			
<b>Pre-Service Total</b>			0.53			
<b>Immediate Post</b>	20	0.0224	0.45			
<b>Post-service</b>	<b># Visits</b>	<b>Discounted RVU</b>	<b>Total RVU</b>	<b>Total Time</b>	<b>Face Time</b>	<b>Total Visit Time</b>
<b>Hospital Visits</b>						
99231		0.64	0.00	19	15	0
99232		1.06	0.00	30	25	0
99233		1.51	0.00	41	35	0
<b>Critical Care</b>						
99291		4.00	0.00	63		0
99292		2.00	0.00	32		0
99296		16.00	0.00	126		0
99297		8.00	0.00	64		0
<b>Discharge Planning</b>						
99238		1.28	0.00	36		0
99239		1.75	0.00	45		0
<b>Office Visits</b>						
99211		0.17	0.00	7	5	0
99212		0.43	0.00	15	10	0
99213		0.65	0.00	23	15	0
99214		1.08	0.00	38	25	0
99215		1.73	0.00	59	40	0
<b>Subsequent Visits</b>	0		0.00	Post		0
				Post		0
<b>Post-Service Total</b>			0.45	Discharge		0
				Total Time		<b>75</b>
<b>Intraservice Time</b>	25					
<b>Intraservice Work</b>	1.22					
<b>IWPUT</b>	<b>0.049</b>					

## SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

---

---

## FREQUENCY INFORMATION

How was this service previously reported? 64425, 64520, 64999 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Anesthesiology \_\_\_\_\_ Commonly \_\_X\_\_ Sometimes \_\_\_\_\_ Rarely

Specialty AAPM \_\_\_\_\_ Commonly \_\_X\_\_ Sometimes \_\_\_\_\_ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

About 7,500 patients per year will receive a hypogastric plexus block

Specialty Anesthesiology Frequency 6,000

Specialty AAPM Frequency 1,500

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

Specialty Anesthesiology Frequency 4,000

Specialty AAPM Frequency 1,000

Do many physicians perform this service across the United States? \_\_X\_\_ Yes \_\_\_\_\_ No

**AMA/Specialty Society Update Process  
 RUC Summary of Recommendation  
 000 Day Global Period  
 In Office Direct Inputs**

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: 000

Tracking Number: FF2 Reference Code 1 \_\_\_\_\_ Reference Code 2 \_\_\_\_\_

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
 \_\_\_\_\_ Single Specialty Group  
 \_\_\_\_\_ Multispecialty Group  
 \_\_\_\_\_ Medical School Faculty Practice Plan

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

We used a consensus committee to develop direct practice expense data. The seven members of the committee come from either a single specialty group or are part of a medical school faculty. There was a wide variety of geographic representation -- East Coast, West Coast, Midwest, South and Upper Midwest -- from both urban and suburban locales. A proposed data set was distributed and the Committee members reviewed. It was refined to reflect the opinions expressed.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The PEAC's pre-service standard for 000 and 010 globals is applicable. All the activities included in the standard package are performed (complete pre-service diagnostic and referral forms, provide pre-service education/obtain consent and appropriate follow up phone calls and prescriptions).

Intra-Service Clinical Labor Activities:

Clinical staff will greet the patient and provide gowning, review the patient's chart and record the patient's vital signs. Clinical staff prepares the room/equipment/supplies needed to perform the service and assists the physician during the procedure and cleans the room/equipment following the procedure.

HCFA's Staff Type Code*	Clinical Labor - Description	Pre-Service Time - Minutes	Service Period (Day of service)	Cost Estimate and Source (if applicable)
1130	RN/LPN/MTA	18	64	

\* From HCFA's Labor, Medical Supply, and Equipment List. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies - Description	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	PEAC Multispecialty Supply Package	1		
	Basic Injection Package	1		
51302	Marcaine (1ml)	20		
73616	Renograph - 60 iodinated contrast	1		
91407	Syringe 10 cc	2		
91411	Syringe 5 cc	2		
91426	Chiba needle	1		

\* From HCFA's Labor, Medical Supply, and Equipment List. If not listed, please provide full description, estimated cost, and cost source.

HCFA Equipment Code*	Medical Equipment - Description	Cost Estimate and Source (if applicable)
E11001	Exam Table	
E51001	X-ray View Box 4 panel	
E51005	Radiographic/fluoroscopic room	

\* From HCFA's Labor, Medical Supply, and Equipment List. If not listed, please provide full description, estimated cost, and cost source.



Monitor pt. following service/check tubes, monitors, drains	15	RN, LPN, MTA
Clean room/equipment by physician staff	3	RN, LPN, MTA
Complete diagnostic forms, lab & X-ray requisitions		
Review/read X-ray, lab, and pathology reports		
Check dressings & wound/ home care instructions/coordinate office visits/prescriptions	3	RN, LPN, MTA
Other Clinical Activity (please specify)		

---

*End: Patient leaves office*

**AMA/Specialty Society Update Process  
RUC Summary of Recommendation  
000 Day Global Period  
Out-Of-Office Direct Inputs**

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: 000

Tracking Number: FF2      Reference Code 1 \_\_\_\_\_ Reference Code 2 \_\_\_\_\_

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %:      \_\_\_\_\_ Solo Practice  
                                  \_\_\_\_\_ Single Specialty Group  
                                  \_\_\_\_\_ Multispecialty Group  
                                  \_\_\_\_\_ Medical School Faculty Practice Plan

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

We used a consensus committee to develop direct practice expense data. The seven members of the committee come from either a single specialty group or are part of a medical school faculty. There was a wide variety of geographic representation -- East Coast, West Coast, Midwest, South and Upper Midwest -- from both urban and suburban locales. A proposed data set was distributed and the Committee members reviewed it. It was revised to reflect the opinions expressed.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The PEAC's pre-service standard for 000 and 010 globals is applicable. All the activities included in the standard package are performed (complete pre-service diagnostic and referral forms, coordinate pre-surgery services, schedule space and equipment in facility, provide pre-service education/obtain consent and appropriate follow up calls and prescriptions.

Intra-Service Clinical Labor Activities:

Provide services to support discharge day management provided.

<b>HCFA's Staff Type Code**</b>	<b>Clinical Labor</b>	<b>Pre-Service Time</b>	<b>Service Period</b>	<b>Coordination of Care*</b>	<b>Cost Estimate and Source (if applicable)</b>
1130	RN/LPN/MTA	30	3		

\*By staff in the physician's office during the service period.

\*\*From HCFA's Labor, Medical Supply, and Equipment List. If not listed, please provide full description, estimated cost, and cost source.

<b>HCFA's Medical Supply Code*</b>	<b>Medical Supplies</b>	<b>Quantity of Supplies</b>	<b>Units Used for Purchase</b>	<b>Cost Estimate and Source (if applicable)</b>

\*From HCFA's Labor, Medical Supply, and Equipment List. If not listed, please provide full description, estimated cost, and cost source.

<b>HCFA's Equipment Code*</b>	<b>Medical Equipment</b>	<b>Cost Estimate and Source (if applicable)</b>

\*From HCFA's Labor, Medical Supply, and Equipment List. If not listed, please provide full description, estimated cost, and cost source.

**TYPE OF SERVICE: Minor Surgical Procedures**  
**000 Global Period**

**SITE OF SERVICE: OUT-OF-OFFICE**

<u><b>Clinical Services</b></u>	<u><b>Minutes</b></u>	<u><b>Staff Type – Circle</b></u>
---------------------------------	-----------------------	-----------------------------------

**Pre-Service Period**

*Start: Following visit when decision for surgery or procedure made*

Complete pre-service diagnostic & referral forms	5	RN, LPN, MTA
Coordinate pre-surgery services	10	RN, LPN, MTA
Schedule space and equipment in facility	5	RN, LPN, MTA
Office visit before surgery/procedure Review test and exam results		
Provide pre-service education/obtain consent	7	RN, LPN, MTA
Follow-up phone calls & prescriptions	3	RN, LPN, MTA
Other Clinical Activity (please specify)		

---

*End: When patient enters hospital for surgery/procedure*

**Service Period**

*Start: Patient admitted to hospital for surgery/procedure*  
*Pre-service services*

- Review charts
  - Greet patient and provide gowning
  - Obtain vital signs
  - Provide pre-service education/obtain consent
  - Prepare room, equipment, supplies
  - Prepare and position patient/ monitor patient/ set up IV
  - Sedate/apply anesthesia
- Intra-service*
- Assist physician in performing surgery/procedure

Monitor patient following service/check tubes, monitors, drains

Clean room/equipment by physician staff

Complete diagnostic forms, lab & X-ray requisitions

Review/read X-ray, lab, and pathology reports

Check dressings & wound/ home care instructions/coordinate  
office visits/prescriptions

Coordination of care by staff in office

Other Clinical Activity (please specify)

3

Telephone call

Discharge day management

*End: Patient leaves facility*

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

---

CPT Code: 64681    Tracking Number: FF3                      Global Period: 010\*    **Recommended RVW: 3.55**  
\* *Originally assigned a 000 global. Changed to 010 subsequent to discussion with CMS.*

CPT Descriptor: Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** A 75-year old male with known prostatic carcinoma and pelvic metastases is suffering from intractable pelvic pain with severe spasms and cramps. Oral medications have not helped him. The patient had been referred to an interventional pain specialist for a superior hypogastric plexus block to relieve his intractable pelvic pain. The patient had a superior hypogastric plexus block which demonstrated 95% pain relief for six hours. Thereafter his pain gradually returned to the original intensity. With the success of a local anesthetic block of the superior hypogastric plexus, the patient is being admitted for a neurolytic block for long-term pain control.

**Percentage of Survey Respondents who found Vignette to be Typical: 94%**  
Respondents indicated that a typical patient would also be a female with chronic pelvic pain.

**Description of Pre-Service Work:**

- History, physical, laboratory review to evaluate for infection and coagulopathy
- Review of old medical records
- Informed consent
- Intravenous access obtained

**Description of Intra-Service Work:** The patient is transferred to the operating room or procedure room. EKG, pulse oximeter and non-invasive blood pressure monitors are applied. Intravenous sedation [*separately reportable*] is titrated to effect. His back is prepared with Betadine. Under imaging guidance (reported separately) a #22 gauge 6 inch spinal needle is inserted to the ventral lateral surface of the spine at the L5-S1 interspace. Once needle position is confirmed using imaging guidance, radiographic contrast is injected on each side to document needle position in the pre-vertebral space just ventral to the psoas fascia. This further demonstrates that the flow is not intra-vascular. The neurolytic block is then performed with a solution of 60% alcohol solution in local anesthetic or a 7-10% Phenol solution. The patient is then transferred to the recovery room for observation for several hours. He will be monitored for early complications of the procedure as well as recovery from conscious sedation.

The complications of the procedure include puncture of the iliac vessels and bleeding, intravascular injection of local anesthetics and neurolytic substances, with seizures, and cardiovascular collapse, nerve injury to the cauda equina or exiting spinal nerves, puncture of the ureters and other pelvic viscera. Infection is always a possibility, especially in immuno-suppressed cancer patients.

**Description of Post-Service Work:**

- Procedure note dictation
- Post-procedure orders
- Pre-discharge evaluation
- Discharge planning
- Subsequent visits to evaluate efficacy of procedure and identify late complications

**SURVEY DATA**

<b>Presenter(s):</b> James D. Grant, M.D., Eduardo M. Fraifeld, M.D.	
<b>Specialty(s):</b> American Society of Anesthesiologists, American Academy of Pain Medicine	
<b>CPT Code:</b> 64681	
<b>Sample Size:</b> 320	<b>Resp n:</b> 48 <b>Resp %:</b> 15%
<b>Sample Type:</b> Panel	
	<b>Low      25th pctl      Median      75th pctl      High</b>
<b>Survey RVW:</b>	2.42      3.15      3.55      4.10      6.00
<b>Pre-Service Evaluation Time:</b>	<u>3</u> <u>10</u> <b>13</b> <u>15</u> <u>30</u>
<b>Pre-Service Positioning Time:</b>	<u>3</u> <u>10</u> <b>10</b> <u>15</u> <u>30</u>
<b>Pre-Service Scrub, Dress, Wait Time:</b>	5 <u>5</u> <b>9</b> <u>15</u> <u>30</u>
<b>Intra-Service Time:</b>	8      20 <b>30</b> 35      60
<b>Post-Service</b>	<b>Total Min*      CPT code / # of visits</b>
<b>Immed. Post-time:</b>	<u>20</u>
<b>Critical Care time/visit(s):</b>	
<b>Other Hospital time/visit(s):</b>	<u>38</u> <u>99231 x 2</u>
<b>Discharge Day Mgmt:</b>	
<b>Office time/visit(s):</b>	

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
64622	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level	010	3.00
64680	Destruction by neurolytic agent, celiac plexus, with or without radiologic monitoring	010	2.62

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

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

**Number of respondents who choose Key Reference Code: Code 64622 18  
Code 64680 23**

**TIME ESTIMATES (Median)**

	<u>New/Revis. CPT Code 646X1</u>	<u>Key Reference CPT Code 64622</u>	<u>Key Reference CPT Code 64680</u>
Median Pre-Service Time	32	17 (Harvard)	20 (Harvard)
Median Intra-Service Time	30	29 (Harvard)	46 (Harvard)
Median Immediate Post-service Time	20	15 (Harvard)	16 (Harvard)
Median Critical Care Time			
Median Other Hospital Visit Time	38		
Median Discharge Day Management Time			
Median Office Visit Time		14 (Harvard)	14 (Harvard)
Median Total Time	120	75	96

**INTENSITY/COMPLEXITY MEASURES (Mean)**

<u>Mental Effort and Judgement (Mean)</u>	<u>New/Revis. CPT Code 646X1</u>	<u>Key Reference CPT Code 64622</u>	<u>New/Revis. CPT Code 646X1</u>	<u>Key Reference CPT Code 64680</u>
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.06	3.70	3.61
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	2.89	3.91	3.78
Urgency of medical decision making	3.89	2.61	3.61	3.65
<b><u>Technical Skill/Physical Effort (Mean)</u></b>				
Technical skill required	4.28	3.06	4.61	4.43
Physical effort required	4.17	2.94	3.87	3.87

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.28	3.06	4.55	4.50
Outcome depends on the skill and judgement of physician	4.50	3.06	4.55	4.50
Estimated risk of malpractice suit with poor outcome	4.50	3.00	4.18	4.23

**INTENSITY/COMPLEXITY MEASURES**

<b>CPT Code</b>	<b>Reference Service</b>	<b>CPT Code</b>	<b>Reference Service</b>
<b>646X1</b>	<b>64622</b>	<b>646X1</b>	<b>64680</b>

**Time Segments (Mean)**

Pre-Service intensity/complexity	4.22	4.00	3.65	3.65
Intra-Service intensity/complexity	4.28	4.11	4.61	4.48
Post-Service intensity/complexity	3.61	3.22	3.74	3.65

---

**ADDITIONAL RATIONALE**

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

After review of the survey results, we recommend a work RVU of 3.55 -- equal to the median. This is in keeping with the fact that the respondents rated the new service as more intense and complex and as requiring more pre- and post-service time compared to the reference services.

A review of the RVUs of other injections listed in the reference service list illustrates that the recommended work RVU correctly rank orders the new code. A neurolytic trigeminal nerve block (CPT 64600) has 3.45 work RVUs. These are much simpler than a neurolytic hypogastric plexus block. In addition, a continuous brachial plexus block (CPT 64416) - a nerve block with a 10 day global period - has 3.50 work RVUs. A trigeminal nerve destruction of foramen ovale (CPT 64610) is valued at 7.16 RVUw.

**IWPUT Calculation:**

This service can be performed in either the inpatient or outpatient setting. Our survey results reflect the use of I/P E/M codes for follow up care provided during the global period. The anesthesiologist/pain medicine physician is called in to do the procedure and is unlikely to plan the discharge.

<b>Pre-Service</b>						
	<b>Minutes</b>	<b>Intensity</b>	<b>RVU's</b>			
<b>Day Prior</b>	13	0.0224	0.29			
<b>Immediate Pre</b>	10	0.0224	0.22			
<b>Scrub, prep</b>	9	0.0081	0.07			
<b>Pre-Service Total</b>			0.59			
<b>Immediate Post</b>	20	0.0224	0.45			
<b>Post-service</b>	<b># Visits</b>	<b>Discounted RVU</b>	<b>Total RVU</b>	<b>Total Time</b>	<b>Face Time</b>	<b>Total Visit Time</b>
<b>Hospital Visits</b>						
99231	2	0.64	1.28	19	15	38
99232		1.06	0.00	30	25	0
99233		1.51	0.00	41	35	0
<b>Critical Care</b>						
99291		4.00	0.00	63		0
99292		2.00	0.00	32		0
99296		16.00	0.00	126		0
99297		8.00	0.00	64		0
<b>Discharge Planning</b>						
99238		1.28	0.00	36		0
99239		1.75	0.00	45		0
<b>Office Visits</b>						
99211		0.17	0.00	7	5	0
99212		0.43	0.00	15	10	0
99213		0.65	0.00	23	15	0
99214		1.08	0.00	38	25	0
99215		1.73	0.00	59	40	0
<b>Subsequent Visits</b>	2		1.28			38
<b>Post-Service Total</b>			1.73			0
				Post		
				Post		
				Discharge		0
				Total Time		120
<b>Intraservice Time</b>	30					
<b>Intraservice Work</b>	1.23					
<b>IWPUT</b>	<b>0.041</b>					

For comparison, please note this list of other codes (which have been valued by the RUC) that have similar intra-service times and can serve for cross-specialty evaluation.

Code 38500 Biopsy or excision of lymph node(s); open, superficial IWPUT = 0.0781

Code 45915 Removal of fecal impaction or foreign body (separate procedure) under anesthesia IWPUT = 0.054

Code 58120 Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical) IWPUT = 0.029



**AMA/Specialty Society Update Process  
RUC Summary of Recommendation  
010 or 090 Day Global Periods  
In Office Direct Inputs**

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: 010

Tracking Number: FF3 Reference Code 1 \_\_\_\_\_ Reference Code 2 \_\_\_\_\_

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
\_\_\_\_\_ Single Specialty Group  
\_\_\_\_\_ Multispecialty Group  
\_\_\_\_\_ Medical School Faculty Practice Plan

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

We used a consensus committee to develop direct practice expense data. The seven members of the committee come from either a single specialty group or are part of a medical school faculty. There was a wide variety of geographic representation -- East Coast, West Coast, Midwest, South and Upper Midwest -- from both urban and suburban locales.

A proposed data set was distributed and the committee members reviewed it. It was revised to reflect the opinions expressed.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The PEAC's pre-service standard for 000 and 010 globals is applicable. All the activities included in the standard package are performed (complete pre-service diagnostic and referral forms, coordinate pre-surgery services, provide pre-service education/obtain consent and appropriate follow up calls and prescriptions).

Intra-Service Clinical Labor Activities:

Clinical staff will greet the patient and provide gowning, review the patient's chart and record vital signs. Clinical staff prepares the room/equipment/supplies needed to perform the service and assists the physician during the procedure and cleans the room/equipment following the procedure.

Post-Service Clinical Labor Activities:

Clinical staff will contact the patient via telephone to check his/her condition. Clinical staff also provides services to support the follow up care provided in the E/M services rendered during the global period.

**CPT Code: 64681**  
**Specialty Society('s) ASA, AAPM**

<b>HCFA's Staff Type Code*</b>	<b>Clinical Labor</b>	<b>Pre-Service Time</b>	<b>Service Period (Day of service)</b>	<b>Post-Service Time After Day of Service)**</b>	<b>Number of Office Visits</b>	<b>Total Time of Office Visits</b>	<b>Cost Estimate and Source (if appropriate)</b>
1130	RN, LPN, MTA	18	66	3	2	54	

\* From HCFA's Labor, Medical Supply, and Equipment List. If not listed, please provide full description, estimated cost, and cost source.

<b>HCFA's Medical Supply Code*</b>	<b>Medical Supplies</b>	<b>Quantity of Supplies</b>	<b>Units Used for Purchase</b>	<b>Cost Estimate and Source (if appropriate)</b>
	PEAC Multispecialty Supply Package	3		
	Basic Injection Package	1		
73616	Renographin-60 iodinated contrast	1		
75113	Phenol, 1000ppm	1		
91407	Syringe 10 cc	2		
91411	Syringe 5 cc	2		
91426	Chiba Needle	1		

\* From HCFA's Labor, Medical Supply, and Equipment List. If not listed, please provide full description, estimated cost, and cost source.

<b>HCFA's Equipment Code*</b>	<b>Medical Equipment</b>	<b>Cost Estimate and Source (if applicable)</b>
E11001	Exam Table	
E51001	X ray View Box 4 panel	
E51005	Radiographic/fluoroscopic room	

\* From HCFA's Labor, Medical Supply, and Equipment List. If not listed, please provide full description, estimated cost, and cost source.

**TYPE OF SERVICE: Surgical Procedures  
010 and 090 Global Periods**

**SITE OF SERVICE: In-OFFICE**

<u>Clinical Services</u>	<u>Minutes</u>	<u>Staff Type – Circle</u>
<b>Pre-Service Period</b>		
<i>Start: Following visit when decision for surgery or procedure made</i>		
Complete pre-service diagnostic & referral forms	5	RN, LPN, MTA
Coordinate pre-surgery services	3	RN, LPN, MTA
Office visit before surgery/procedure Review test and exam results	0	RN, LPN, MTA
Provide pre-service education/obtain consent	7	RN, LPN, MTA
Follow-up phone calls & prescriptions	3	RN, LPN, MTA
Other Activity (please specify)		
<hr/>		
<i>End: When patient enters office for surgery/procedure</i>		
<b>Service Period</b>		
<i>Start: When patient enters office for surgery/procedure</i>		
<i>Pre-service services</i>		
Review charts	2	RN, LPN, MTA
Greet patient and provide gowning	3	RN, LPN, MTA
Obtain vital signs	3	RN, LPN, MTA
Provide pre-service education/obtain consent		
Prepare room, equipment, supplies	5	RN, LPN, MTA
Prepare and position patient/ monitor patient/ set up IV	2	RN, LPN, MTA
Sedate/apply anesthesia		
<i>Intra-service</i>		
Assist physician in performing procedure	30	RN, LPN, MTA

**CPT Code: 64681**  
**Specialty Society('s) ASA, AAPM**

*Post-service*

Monitor pt. following service/check tubes, monitors, drains	15	RN, LPN, MTA
Clean room/equipment	3	RN, LPN, MTA
Complete diagnostic forms, lab & X-ray requisitions		
Review/read X-ray, lab, and pathology reports		
Check dressings & wound/ home care instructions/coordinate office visits/prescriptions	3	RN, LPN, MTA
Other Activity (please specify)		

*End: Patient leaves office*

**Post-Service Period**

*Start: Patient leaves office*

Conduct phone calls/call in prescriptions	3	RN, LPN, MTA
---	---	--------------

*Office visits*

Greet patient, escort to room		
Provide gowning		
Interval history & vital signs & chart		
Assemble previous test reports/results		
Assist physician during exam		
Assist with dressings, wound care, suture removal		
Prepare Dx test, prescription forms		
Post service education, instruction, counseling		
Clean room/equip, check supplies		RN, LPN, MTA
Coordinate home or outpatient care	A 27	

**List total number of office visits** **B 2**

**Total office visit time (A \* B)** **54**

Conduct phone calls between office visits

Other Activity (please specify)

*End: With last office visit before end of global period*

**AMA/Specialty Society Update Process  
RUC Summary of Recommendation  
010 or 090 Day Global Periods  
Out-Of-Office Direct Inputs**

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: 010

Tracking Number: FF3      Reference Code 1 \_\_\_\_\_ Reference Code 2 \_\_\_\_\_

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %:      \_\_\_\_\_ Solo Practice  
                                  \_\_\_\_\_ Single Specialty Group  
                                  \_\_\_\_\_ Multispecialty Group  
                                  \_\_\_\_\_ Medical School Faculty Practice Plan

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

We used a consensus committee to develop direct practice expense data. The seven members of the committee came from either . single specialty group or are part of a medical school faculty. There was a wide variety of geographic representation -- East Coast, West Coast, Midwest, South and Upper Midwest-- from both urban and suburban locales. A proposed data set was distributed and the committee members reviewed it. It was revised to reflect the opinions expressed.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The PEAC's pre-service standard for 000 and 010 globals is applicable. All the activities included in the standard package are performed (complete pre-service diagnostic and referral forms, coordinate pre-surgery services, schedule space and equipment in facility, provide pre-service education/obtain consent and appropriate follow up calls and prescriptions.

Intra-Service Clinical Labor Activities:

Provide services to support discharge day management.

Post-Service Clinical Labor Activities:

Clinical staff will contact the patient via telephone to check his/her condition. Clinical staff also provides service to support the follow up care provided in the E/M services rendered during the global period.





*Post-service*

Monitor pt. following service/check tubes, monitors, drains	_____	RN, LPN, MTA, Other
Clean room/equipment by physician staff	_____	RN, LPN, MTA, Other
Assist with ICU or hospital visits	_____	RN, LPN, MTA, Other
<b>Total Number of ICU visits</b>	_____	
<b>Total Number of hospital visits</b>	_____	
Complete diagnostic forms, lab & X-ray requisitions	_____	RN, LPN, MTA, Other
Review/read X-ray, lab, and pathology reports	_____	RN, LPN, MTA, Other
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions		_____
Coordination of care by staff in office	_____	RN, LPN, MTA, Other
Other Activity (please specify)		_____
_____	_____	RN, LPN, MTA, Other

*End: Patient discharge from hospital*

**Post-Service Period**

*Start: Patient discharge from hospital*

Conduct phone calls/call in prescriptions	3	RN, LPN, MTA
Office visits		
Greet patient, escort to room		
Provide gowning		
Interval history & vital signs & chart		
Assemble previous test reports/results		
Assist physician during exam		
Assist with dressings, wound care, suture removal		
Prepare Dx test, prescription forms		
Post service education, instruction, counseling		
Clean room/equip, check supplies		
Coordinate home or outpatient care	A	

**List total number of office visits** B

**Total office visit time (A \* B)**

Conduct phone calls between office visits

Other Activity (please specify)

*End: With last office visit before end of global period*

	A	B	C	D	E	F	G	H
1								
2			64449		64517		64681	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Injection; anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement). Including daily management for anesthetic agent administration (Do not report 01996 in addition to 6444X)		Injection; anesthetic agent; superior hypogastric plexus		Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus	
4	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office
5	GLOBAL PERIOD		10	10	0	0	10	10
6	TOTAL CLINICAL LABOR TIME		0.0	3.0	82.0	33.0	141.0	3.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		0.0	0.0	18.0	30.0	18.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		0.0	0.0	61.0	0.0	66.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		0.0	3.0	3.0	3.0	57.0	3.0
10	PRE-SERVICE							
11	Start: Following visit when decision for surgery or procedure made		Not typically performed in office					
12	Complete pre-service diagnostic & referral forms	1130			5	5	5	
13	Coordinate pre-surgery services	1130			3	10	3	
14	Schedule space and equipment in facility	1130			0	5	0	
15	Provide pre-service education/obtain consent	1130			7	7	7	
16	Follow-up phone calls & prescriptions	1130			3	3	3	
17	Other Clinical Activity (please specify)							
18	End: When patient enters office/facility for surgery/procedure							
19	SERVICE PERIOD							
20	Start: When patient enters office/facility for surgery/procedure							
21	Pre-service services							
22	Review charts	1130			2		2	
23	Greet patient and provide gowning	1130			3		3	
24	Obtain vital signs	1130			3		3	
25	Provide pre-service education/obtain consent							
26	Prepare room, equipment, supplies	1130			5		5	
27	Prepare and position patient/ monitor patient/ set up IV	1130			2		2	
28	Intra-service							
29	Assist physician in performing procedure	1130			25		30	
30	Post-Service							
31	Monitor pt following service/check tubes, monitors, drains	1130			15		15	
32	Clean room/equipment by physician staff	1130			3		3	
33	Clean Scope							
34	Complete diagnostic forms, lab & X-ray requisitions							
35	Review/read X-ray, lab, and pathology reports							
36	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	1130			3		3	
37	Discharge day management 99238 --12 minutes 99239 --15 minutes	1130						
38	Other Clinical Activity (please specify)							
39	End: Patient leaves office							
40	POST-SERVICE Period							
41	Start: Patient leaves office/facility							
42	Conduct phone calls/call in prescriptions	1130		3	3	3	3	3
43	Office visits Greet patient, escort to room, provide gowning, interval history & vital signs and chart, assemble previous test reports/results, assist physician during exam, assist with dressings, wound care, suture removal, prepare dx test, prescription forms, post service education, instruction, counseling, clean room/equip, check supplies, coordinate home or outpatient care							
44	List Number and Level of Office Visits							
45	99211 16 minutes	16						
46	99212 27 minutes	27					2	
47	99213 36 minutes	36						
48	99214 53 minutes	53						
49	99215 63 minutes	63						
50								
51								
52	Total Office Visit Time		0	0	0	0	54	
53	Other Activity (please specify)							
54	End: with last office visit before end of global period							

AMA Specialty Society Recommendation

	A	B	C	D	E	F	G	H
2			64449		64517		64681	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration (Do not report 01996 in addition to 6444X)		Injection; anesthetic agent; superior hypogastric plexus		Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus	
4	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office
55	MEDICAL SUPPLIES							
56	PEAC multispecialty supply package				1		3	
57	Basic Injection Package				1		1	
58	Marcaine (1ml)	51302			20			
59	Renographin-60 iodinated contrast	73616			1		1	
60	Phenol, 1000 ppm	75113			0		1	
61	Syrnng 10cc	91407			2		2	
62	Syrnng 5cc	91411			2		2	
63	Chiba needle	91426			1		1	
64								
65	Equipment							
66	Exam Table	E11001			x		x	
67	X-ray View Box 4 panel	E51001			x		x	
68	Radiographic/ fluoroscopic room	E51005					x	

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2003

*Amniotic Membrane Transplant*

The CPT Editorial Panel created four new CPT codes to describe amniotic membrane transplantation. These are relatively rare procedures which will be provided to Medicare patients less than 500 times per year. Ophthalmology conducted a survey and presented its recommendations, based on the survey data and review of a consensus panel. The RUC agreed that the recommendations presented by ophthalmology were appropriate, in comparison to reference services as described below.

*65780 Ocular surface reconstruction; amniotic membrane transplantation:* The survey time for 65780 was 60 minutes pre-time, 60 minutes intra-time, and 185 minutes total post-time. The pre-and post-time was greater than key reference service 65750 *Keratoplasty (corneal transplant); penetrating (in aphakia)* (work RVU = 15.00) with pre-time of 40 minutes and total post-time of 158 minutes. However, the intra-service time for 65780 was 60 minutes, versus 90 minutes for 65750. The RUC agreed with the specialty that the 25<sup>th</sup> percentile of the surveyed work value of 10.25 was a more appropriate representation of the work, as the intra-service period is 1/3 less time and the respondents viewed intensities of these two services as comparable. **The RUC recommends a work relative value of 10.25 for CPT code 65780.**

*65781 Ocular surface reconstruction; limbal stem cell allograft (eg, cadaveric or living donor):* The survey time for 65781 was 60 minutes pre-time, 90 minutes intra-time, and 193 minutes post-time, compared to the time for 65750 (40 minutes pre-, 90 minutes intra-, and 158 minutes post). The RUC agreed that the intensity of 65781 is greater than 65750 and noted the greater pre-, and post-time for the new service. The RUC also compared this service across specialties to CPT code 44120 *Enterectomy, resection of small intestine; single resection and anastomosis* (work RVU = 17.00), with intra-service time of 90 minutes and comparable pre- and post-time. The RUC agreed with the specialty societies recommendation of 17.67, which is slightly less than the survey median. **The RUC recommends a work relative value of 17.67 for CPT code 65781.**

*65782 Ocular surface reconstruction; limbal conjunctival autograft (includes obtaining graft):* The survey time for 65782 is nearly identical to the time for 65760 (60 minutes pre-time, 83 minutes intra-time, and 178 post-time), and the specialty presented that the intensity of this new service is higher than the reference service. The RUC also reviewed services performed by other specialties, such as 43610 *Excision, local; ulcer or benign tumor of stomach* (work RVU = 14.60) and 35266 *Repair blood vessel with graft other than vein;*

*upper extremity* (work RVU = 14.91) with comparable intra-service times and agreed that the service was appropriately valued across specialties. The RUC agreed that the survey median, as presented by the specialty society was appropriate. **The RUC recommends a work relative value of 15.00 for CPT code 65782.**

*68371 Harvesting conjunctival allograft, living donor:* The RUC compared the survey data and time for this new service (pre-time of 30 minutes, intra-time of 20 minutes, and post-time of 95 minutes) to two reference codes 65870 *Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); anterior synechiaw, except goniosynechia* (work RVU = 6.27, pre-time = 20 minutes, intra-time = 33 minutes; and post-time = 106 minutes) and 65855 *Trabeculoplasty by laser surgery, one or more sessions (defined treatment series)* (work rvu = 3.85, pre-time = 15, intra-time = 15, and post-time = 55). The RUC agreed that the 25% of the survey was appropriate at 4.90 work values. **The RUC recommends a work relative value of 4.90 for CPT code 68371.**

Practice Expense:

The RUC accepted the specialty society’s recommended direct practice expense inputs, which were based on the PEAC standards for pre-time and post-procedure visits. These procedures are all performed in a facility setting.

CPT Code (•New)	Track ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
•65780	O1	Ocular surface reconstruction; amniotic membrane transplantation	090	10.25
•65781	O2	limbal stem cell allograft (eg, cadaveric or living donor)	090	17.67
•65782	O3	limbal conjunctival autograft (includes obtaining graft) (For harvesting conjunctival allograft, living donor, see 68371)	090	15.00
•68371	O4	Harvesting conjunctival allograft, living donor	010	4.90

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

CPT Code: 65780\_\_\_ Tracking Number: O1 Global Period: 90 Recommended RVW: 10.25

CPT Descriptor:

**Ocular surface reconstruction; amniotic membrane transplantation**

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: **A 48 year old woman with neurotrophic keratopathy has a persistent corneal epithelial defect which has failed to heal after treatment with lubricants and a bandage contact lens. There is significant corneal thinning with a high risk of perforation.**

**Description of Pre-Service Work:**

Preoperative work begins after the decision for surgery has been made, from the day before surgery until the procedure begins. The preoperative workup, including history, physical examination and laboratory studies, are reviewed. Informed consent is obtained if not previously done. Surgical attire is donned. Necessary surgical instruments and supplies are reviewed with the operating room staff. The patient is positioned on the operating room table and the operative eye marked. Local (peribulbar or retrobulbar) anesthesia is administered. A surgical scrub is performed and sterile gloves and gown are donned. Prepping and draping of the surgical site is supervised.

**Description of Intra-Service Work:**

A plastic adhesive drape is applied to the operative eye and incised. A lid speculum is inserted so that the lid margins and lashes are isolated from the operative field. The operating microscope is swung into position and adjusted. Micro-tip cellulose sponges and .12 forceps are used to debride necrotic corneal epithelium. Preserved human amniotic membrane is first removed from the storage medium and peeled from the nitrocellulose filter paper on which it is supplied. A piece of membrane is trimmed with scissors to fit the area of corneal thinning. The smooth basement membrane surface is distinguished from the sticky stromal surface by touching it with a micro-tip sponge. The membrane is placed with the basement membrane surface up, and is anchored into place with multiple interrupted 10-0 nylon sutures. The suture ends are trimmed and rotated flush with or below the surface of the corneal epithelium. Additional pieces of amniotic membrane (2-4) are trimmed to fit the area of thinning, placed basement membrane surface up, and anchored into place with interrupted 10-0 nylon sutures until the area of thinning is flush with surrounding normal-thickness cornea. All of the knots are buried. The lid speculum and drapes are removed. A bandage contact lens is placed with topical antibiotic-steroid ointment.

**Description of Post-Service Work:**

Postoperative work begins after the patient leaves the operating room, and includes monitoring of patient stabilization; communication with family members and other health care professionals; and generation of written and oral reports of the surgery and postoperative orders in the post-anesthesia care unit. Discharge plans are written and discharge records completed, including instructions for continuing care, postoperative pain medication, topical antibiotics, and steroids. Prescriptions are written for postoperative medications.

Additionally, all post-discharge visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure. Office visits for evaluation and monitoring for development of infectious keratitis or further thinning are performed daily for 5 days, then twice monthly for the next 60 days, with one additional visit during the global period. Sutures are removed and monitoring is continued until the ocular surface stabilizes. Topical medications are tapered as needed and instructions for use of topical lubricants are given. The patient is evaluated for return to normal active function at each postoperative visit. Phone calls to the patient, family, referring physician, and other health care professionals during this time period are included in the postoperative work.

**SURVEY DATA:**

Presenter(s)\_ Stephen Kamenetzky, M.D, Trex Topping, M.D., David Glasser, M. D.

Specialty(s) AAO, ASCRS

Sample Size: 200 Response Rate: (%): 17 Median RVW: 13

Type of Sample (Circle One): **random**, panel, convenience. Explanation of sample size:  
The American Academy of Ophthalmology sent out the surveys to 200 members randomly selected. The surveyed were geographically diverse. The type of practice was varied.

25th Percentile RVW: 10.25 75th Percentile RVW: 15 Low: 3.68 High: 25

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

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 60 Low: 30 High: 120

Median Post-Service Time:	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code &amp; # of Visits)</u>
Immediate Post Service Time:	<u>17</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>N/A</u>	
Discharge Day Mgmt.:	<u>18</u>	<u>99238</u>
Office Visits:	<u>150</u>	<u>99212 (10)</u>

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
65750	Keratoplasty (corneal transplant); penetrating (in aphakia)	15

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

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

<b><u>TIME ESTIMATES (Median)</u></b>	<b>New/Revis. CPT Code:</b>	<b>Key Reference CPT Code:</b>
Median Pre-Time	60	40
Median Intra-Time	60	90
Median Immediate Post-service Time	17	20
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	18	N/A
Median of Aggregate Office Visit Times	150	138
<b><u>INTENSITY/COMPLEXITY MEASURES (Mean)</u></b>		
<b><u>Mental Effort and Judgement (Mean)</u></b>		
The number of possible diagnosis and/or the number of management options that must be considered	4.06	3.6
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.75	4
Urgency of medical decision making	4.38	3.8
<b><u>Technical Skill/Physical Effort (Mean)</u></b>		
Technical skill required	4.0	4.2
Physical effort required	3.69	4.3
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	3.94	4.1

Outcome depends on the skill and judgement of physician	4 19	4.6
Estimated risk of malpractice suit with poor outcome	3 25	3 6

<u>INTENSITY/COMPLEXITY MEASURES</u>	<u>CPT Code</u>	<u>Reference Service 1</u>
<u>Time Segments (Mean)</u>		
Pre-Service intensity/complexity	4	4
Intra-Service intensity/complexity	4	4
Post-Service intensity/complexity	4	3.5

**ADDITIONAL RATIONALE**

The committee reviewed the data for this code, and decided that the median survey value was too high. Compared with the reference code (65750), the pre-service and post-service times were higher than the reference. However the intraservice time was significantly lower. For that reason, the committee chose to use the 25<sup>th</sup> percentile for its recommendation.

**FREQUENCY INFORMATION**

How was this service previously reported? \_\_A poll of specialists found that they most commonly use 66999. Other possible codes are 65711, 68360, 68362, and 68399.

(if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty AAO \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes X Rarely

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAO \_\_\_\_\_ Frequency < 1000 \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty AAO Frequency < 500

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Post-op visits for 65780: Ocular surface reconstruction; amniotic membrane transplantation

10 level-2 visits

**Day 1:** Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding postoperative pain, discharge or bleeding, post-anesthesia reactions, use of oral medication recorded by technician. Tape and bandage removed. Periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers additional drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. The size of the epithelial defect is measured with the slit lamp millimeter rule and a drawing of the graft and defect recorded. Intraocular pressure is measured with pneumotonometer or Tonopen. Tip of instrument cleaned with alcohol pad. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. The eye is patched with 1-2 eye pads and paper or plastic tape. Slit lamp chin-rest papers are replaced.

Patient signs out and follow-up appointments are made for days 2-5.

**Day 2:** Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding postoperative pain, discharge or bleeding, use of oral medication recorded by technician. Tape and bandage removed. Periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers additional drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. The size of the

epithelial defect is measured with the slit lamp millimeter rule and a drawing of the graft and defect recorded. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. The eye is patched with 1-2 eye pads and paper or plastic tape. Slit lamp chin-rest papers are replaced.

**Day 3:** Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding postoperative pain, discharge or bleeding, use of oral medication recorded by technician. Tape and bandage removed. Periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers additional drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. The size of the epithelial defect is measured with the slit lamp millimeter rule and a drawing of the graft and defect recorded. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. The eye is patched with 1-2 eye pads and paper or plastic tape. Slit lamp chin-rest papers are replaced.

**Day 4:** Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding postoperative pain, discharge or bleeding, use of oral medication recorded by technician. Tape and bandage removed. Periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers additional drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. The size of the epithelial defect is measured with the slit lamp millimeter rule and a drawing of the graft and defect recorded. Intraocular pressure is measured with pneumotonometer or Tonopen. Tip of instrument cleaned with alcohol pad. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied

topically. The eye is patched with 1-2 eye pads and paper or plastic tape. Slit lamp chin-rest papers are replaced.

**Days 5-10** (1 visit, typically on day 5): Patient signed in at front desk.

Technician greets patient and brings back to screening lane. History regarding qualitative visual symptoms, postoperative pain, discharge or bleeding, use of oral medication recorded by technician. Tape and bandage removed. Periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers additional drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft integrity and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. The size of the epithelial defect, if present, is measured with the slit lamp millimeter rule and a drawing of the graft and any remaining defect recorded. Loose sutures are removed with jeweler's or McPherson forceps and disposable super sharp blade, and any devitalized amniotic membrane material at the edges of the graft are trimmed with a Vannas scissors at the slit-lamp microscope. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. Typically, the epithelium is healed, so no patching is necessary. If an epithelial defect remains, the eye is patched with 1-2 eye pads and paper or plastic tape. Prescriptions are written for topical antibiotic and steroid drops, and the patient is instructed in frequency of application. Slit lamp chin-rest papers are replaced.

Patient signs out and makes appointment for return visit.

**Days 11-30** (2 visits, typically identical): Patient signed in at front desk.

Technician greets patient and brings back to screening lane. History regarding qualitative visual symptoms, postoperative pain, discharge or bleeding, use of topical medication recorded by technician. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft integrity and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating

solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. If epithelium is breaking down (uncommon), lower and upper lid punctum plugs are placed. If loss of the graft with keratolysis and threatened perforation is present (rare), cyanoacrylate glue and a therapeutic contact lens are placed. Intraocular pressure is measured with pneumotonometer or Tonopen. Tip of instrument cleaned with alcohol pad. Loose sutures are removed with jeweler's or McPherson forceps and disposable super sharp blade. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. Instructions on adjusting the doses of topical steroids and antibiotics are reviewed. Slit lamp chin-rest papers are replaced.

Patient signs out and makes appointment for return visit.

**Days 31-60** (2 visits): Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding qualitative visual symptoms, postoperative pain or discharge, and use of topical medications is recorded by technician. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers drop of topical anesthetic, drop of cycloplegic, and drop of mydriatic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft integrity and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. Intraocular pressure is measured with pneumotonometer or Tonopen. Tip of instrument cleaned with alcohol pad. During the first of the 2 visits during this period, any remaining sutures are removed with jeweler's or McPherson forceps and disposable super sharp blade. Once the eye has dilated, a fundus examination is performed. If sutures were removed, antibiotic ophthalmic ointment is applied topically. Instructions on adjusting the doses of topical antibiotics and steroids are reviewed. Slit lamp chin-rest papers are replaced.

Patient signs out and makes appointment for return visit.

**Days 61-90** (1 visit): Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding qualitative visual symptoms, postoperative pain or discharge, and use of topical medications are recorded by technician. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft integrity and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. Intraocular pressure is measured with pneumotonometer or Tonopen. Tip of instrument cleaned with alcohol pad. Instructions on adjusting the doses of topical antibiotics and steroids are reviewed. Slit lamp chin-rest papers are replaced.

Patient signs out and makes appointment for return visit.

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

---

CPT Code: 65781\_\_\_ Tracking Number: 02\_\_\_ Global Period: 90\_\_\_ Recommended RVW: 17.67\_\_\_

CPT Descriptor:

**Ocular surface reconstruction; limbal stem cell allograft (eg, cadaveric or living donor)**

---

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: **A 47 year old male with severe corneal scarring secondary to Stevens-Johnson syndrome and insufficient viable conjunctival epithelium remaining to allow healing.**

**Description of Pre-Service Work:**

Preoperative work begins after the decision for surgery has been made, from the day before surgery until the procedure begins. The preoperative workup, including history, physical examination and laboratory studies, are reviewed. Informed consent is obtained if not previously done. Surgical attire is donned. Necessary surgical instruments and supplies are reviewed with the operating room staff. The patient is positioned on the operating room table and the operative eye marked. Local (peribulbar or retrobulbar) anesthesia is administered. A surgical scrub is performed and sterile gloves and gown are donned. Prepping and draping of the surgical site is supervised.

**Description of Intra-Service Work:**

A plastic adhesive drape is applied to the operative eye and incised. A lid speculum is inserted so that the lid margins and lashes are isolated from the operative field. A lateral canthotomy is performed, if necessary, to enable expansion of the lid speculum and attain adequate exposure. The operating microscope is swung into position and adjusted.

The cadaveric keratolimbal allografts are then prepared from the donor corneoscleral rim. The central donor cornea is excised with a 7.5 mm trephine, avoiding trauma to the limbal stem cells. The remaining corneoscleral rim is sectioned into equal halves. Scissors are used to dissect excess peripheral tissue, leaving approximately 1 mm of sclera peripheral to the limbus. The posterior one-half to two-thirds of each hemisection is removed under the operating microscope by lamellar dissection using a sharp rounded steel crescent blade, while an assistant stabilizes the tissue with forceps. The remaining grafts are placed epithelial side up in storage media solution while awaiting placement later in the procedure.

A 360-degree limbal conjunctival peritomy is performed on the recipient. In areas of symblepharon, conjunctival tissue is first recessed at the limbus and then undermined to allow the tissue to fall back. The symblepharon are used to reconstruct the fornix and provide epithelium for the palpebral surface. Adherent areas of conjunctiva are excised, along with a limbal skirt of subconjunctival scar tissue and Tenon's capsule. The conjunctiva is resected to expose bare sclera for 4-5 mm posterior to the limbus for 360 degrees. Wet-field cautery, topical adrenergics, and thrombin are used to arrest bleeding from the highly vascularized field if waiting for normal clotting mechanisms does not result in adequate hemostasis. Significant bleeding may necessitate dissection of the conjunctiva one quadrant at a time.

Abnormal fibrovascular pannus and corneal epithelium are then removed from the underlying corneal stroma, using blunt dissection with cellulose surgical microsponges, followed by semi-sharp lamellar dissection with a rounded steel blade or Westcott scissors to create a smooth surface. Care is taken to maintain an anterior lamellar dissection, leaving deeper stromal layers intact. Topical adrenergics and thrombin are used to control bleeding.

The two living-donor conjunctival limbal allografts, previously harvested in a separate procedure, are sutured into place at 6 and 12 o'clock with the limbal edge at the recipient limbus, using interrupted 10-0 nylon or polyglactin sutures. The two previously prepared crescents of cadaveric keratolimbal tissue are sutured into place, centered at 3 and 9 o'clock, with interrupted 10-0 nylon or polyglactin sutures so that the corneal edges of the donor material just overly the recipient limbus. The recipient limbus should be covered with donor limbal tissue for 360 degrees. Viscoelastics and balanced salt solution are used to prevent dessication of the donor tissue during suturing. The free edges of the recessed recipient conjunctiva are sutured to the posterior edges of the donor tissue. The lid speculum and drapes are removed. The eye is patched with antibiotic and corticosteroid ointment, and covered with a shield.

**Description of Post-Service Work:**

Postoperative work begins after the patient leaves the operating room, and includes monitoring of patient stabilization; communication with family members and other health care professionals; and generation of written and oral reports of the surgery and postoperative orders in the post-anesthesia care unit. Discharge plans are written and discharge records completed, including instructions for continuing care, postoperative pain medication, topical antibiotics, and steroids. Prescriptions are written for postoperative medications.

Additionally, all post-discharge visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure. Office visits for evaluation and monitoring for development of infectious keratitis and physical integrity of the grafts are performed daily for 5 days, then twice a month for 60 days with one additional visit during the 90 day post operative period. A bandage contact lens may be fit to protect the grafts from the lid. Sutures are removed and monitoring for rejection and stabilization of the ocular surface continues during the postoperative period. Topical antibiotics are discontinued when re-epithelialization is complete. Topical corticosteroids are prescribed 4 times a day and tapered gradually to once a day as appropriate, with monitoring for epithelial healing and intraocular pressure. The pharmacy is instructed in the preparation of topical cyclosporin A, which is administered 4 times a day, and the corneal epithelium is monitored for toxicity of the vehicle. The patient is instructed in the use of topical lubricants.

Postoperative care is intense due to the requirement for systemic as well as local immune suppression. Oral corticosteroids are given in a dosage of 1 mg/kg/day initially, with a taper over 6 months, and the patient is monitored for adverse consequences of systemic corticosteroid therapy (glucose, lipids, blood pressure, intraocular pressure, weight, gastritis, and bone density). Oral cyclosporin A therapy is initiated at 3 mg/kg/day, with monitoring of blood levels and adjustment of dosage to maintain serum levels at 100-150 ng/dl for 12-18 months. Regular monitoring of serum creatinine, lipids and minerals; blood pressure; urinalysis; liver function tests; and blood counts are performed. Tacrolimus (FK-506) may be used instead of cyclosporin A, with appropriate monitoring for nephrotoxicity, hypertension, neurotoxicity, hyperglycemia, and hyperlipidemia. Mycophenolate is administered orally or intravenously in a dose of 1 gm/day for 12-18 months, with monitoring of blood counts and chemistries. Azathioprine 100 mg/day may be substituted for mycophenolate, with monitoring of blood counts and liver function tests.

The patient is evaluated for return to normal active function at each postoperative visit. Phone calls to the patient, family, referring physician, and other health care professionals during this time period are included in the postoperative work.

**SURVEY DATA:**

Presenter(s) Stephen Kamenetzky, M.D, Trex Topping, M.D., David Glasser, M. D.

Specialty(s): AAO, ASCRS

Sample Size: 200 Response Rate: (%): 17 Median RVW: 18

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: The American Academy of Ophthalmology sent out the surveys to 200 members randomly selected. The surveyed were geographically diverse. The type of practice was varied.

25th Percentile RVW: 13.5 75th Percentile RVW: 18.78 Low 2\_ High: 50

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

25th Percentile Intra-Svc Time: 80 75th Percentile Intra-Svc Time: 120 Low: 45 High: 200

Median Post-Service Time:	<u>Total Time</u>	Level of Service by CPT Code (List CPT Code & # of Visits)
Immediate Post Service Time:	<u>25</u>	
Critical Care:	<u>N/A</u>	

Other Hospital Visits:           N/A          

Discharge Day Mgmt.:           18                     1/2 99238          

Office Visits:           150                     99212 (10)          

CPT Code:           657X1          

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
65750	Keratoplasty (corneal transplant); penetrating (in aphakia)	15

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

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

**TIME ESTIMATES (Median)**

<b>New/Revis.</b>	<b>Key Reference</b>
<b>CPT Code:</b>	<b>CPT Code:</b>

Median Pre-Time	60	40
Median Intra-Time	90	90
Median Immediate Post-service Time	25	20
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	18	N/A
Median of Aggregate Office Visit Times	150	138

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.47	3.9
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.40	3.7
Urgency of medical decision making	4.53	3.6

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.67	4.5
Physical effort required	4.47	4.2

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.67	4.4
Outcome depends on the skill and judgement of physician	4.67	4.3
Estimated risk of malpractice suit with poor outcome	3.73	4

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	4.47	3.89
Intra-Service intensity/complexity	4.53	3.78
Post-Service intensity/complexity	4.40	3.67

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

The committee chose the mean for the recommended value for this code. All of the intensity and complexity measures are significantly higher than the reference code (65750). The pre-service time, the immediate post service time and total post service times are significantly greater than the reference as well. The intra service time is only slightly less. The committee felt therefore that the mean accurately reflected the physician work value for the proposed code.

In addition the committee reviewed some of the other codes that had recently been considered by the RUC. Code 44120, which was reviewed at the August 2000 meeting, has the same intra-service and pre-service times and virtually the same post service time. The total times were similar as well and the RVU for 44120 was 17.00.

---

**FREQUENCY INFORMATION**

How was this service previously reported?    A poll of specialists found that they most commonly use 66999. Other possible codes are 65711, 68360, 68362, and 68399.

(if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty    AAO       Commonly    Sometimes    X    Rarely

Specialty       Commonly    Sometimes    Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAO Frequency < 1000

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty AAO Frequency < 500

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

---

Post-op visits for 65781: Ocular surface reconstruction; limbal stem cell allograft (eg cadaveric or living donor)

10 level-2 visits

**Day 1:** Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding postoperative pain, discharge or bleeding, post-anesthesia reactions, use of oral analgesics and immune suppressive medication recorded by technician. Tape and bandage removed. Periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Recommendations from consultant managing systemic immune suppression reviewed. Physician administers additional drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. The size of the epithelial defect is measured with the slit lamp millimeter rule and a drawing of the defect recorded. Intraocular pressure is measured with pneumotonometer or Tonopen. Tip of instrument cleaned with alcohol pad. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. The eye is patched with 1-2 eye pads and paper or plastic tape. Patient counseled on use of oral immune suppressive medications. Slit lamp chin-rest papers are replaced.

Patient signs out and follow-up appointments are made for days 2-5.

**Day 2:** Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding postoperative pain, discharge or bleeding, use of oral analgesics and immune suppressive medication recorded by technician. Tape and bandage removed. Periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers additional drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with

irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. The size of the epithelial defect is measured with the slit lamp millimeter rule and a drawing of the defect recorded. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. The eye is patched with 1-2 eye pads and paper or plastic tape. Use of oral medications reviewed. Slit lamp chin-rest papers are replaced.

**Day 3:** Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding postoperative pain, discharge or bleeding, use of oral analgesics and immune suppressive medication recorded by technician. Tape and bandage removed. Periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers additional drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. The size of the epithelial defect is measured with the slit lamp millimeter rule and a drawing of the defect recorded. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. The eye is patched with 1-2 eye pads and paper or plastic tape. Use of oral medications reviewed. Slit lamp chin-rest papers are replaced.

**Day 4:** Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding postoperative pain, discharge or bleeding, use of oral medication recorded by technician. Tape and bandage removed. Periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers additional drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-

examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. The size of the epithelial defect is measured with the slit lamp millimeter rule and a drawing of the defect recorded. Intraocular pressure is measured with pneumotonometer or Tonopen. Tip of instrument cleaned with alcohol pad. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. The eye is patched with 1-2 eye pads and paper or plastic tape. Use of oral medications reviewed. Slit lamp chin-rest papers are replaced.

**Days 5-10** (1 visit, typically on day 5): Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding qualitative visual symptoms, postoperative pain, discharge or bleeding, use of oral medication recorded by technician. Tape and bandage removed. Periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers additional drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft integrity and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. The size of the epithelial defect, if present, is measured with the slit lamp millimeter rule and a drawing of the defect recorded. Loose sutures are removed with jeweler's or McPherson forceps and disposable super sharp blade, and any devitalized tissue at the edges of the graft are trimmed with a Vannas scissors at the slit-lamp microscope. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. Typically, the epithelium is healed, so no patching is necessary. If an epithelial defect remains, the eye is patched with 1-2 eye pads and paper or plastic tape. Prescriptions are written for topical antibiotic and steroid drops, and the patient is instructed in frequency of application. Use of oral medications reviewed. Slit lamp chin-rest papers are replaced.

Patient signs out and makes appointment for return visit.

**Days 11-30** (2 visits, typically identical): Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding qualitative visual symptoms, postoperative pain, discharge or bleeding, use of topical and oral medication recorded by technician. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Recommendations from consultant managing systemic immune suppression reviewed. Physician administers drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft integrity and suture placement, evidence of stromal thinning, infiltrates, perforation, graft rejection. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. If epithelium is breaking down (uncommon), lower and upper lid punctum plugs are placed. If keratolysis with threatened perforation is present (rare), cyanoacrylate glue and a therapeutic contact lens are placed. Intraocular pressure is measured with pneumotonometer or Tonopen. Tip of instrument cleaned with alcohol pad. Loose sutures are removed with jeweler's or McPherson forceps and disposable super sharp blade. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. Instructions on adjusting the doses of topical steroids and antibiotics and use of oral immune suppressives are reviewed. Slit lamp chin-rest papers are replaced.

Patient signs out and makes appointment for return visit.

**Days 31-60** (2 visits): Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding qualitative visual symptoms, postoperative pain or discharge, and use of topical and oral medications is recorded by technician. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Recommendations from consultant managing systemic immune suppression reviewed. Physician administers drop of topical anesthetic, drop of cycloplegic, and drop of mydriatic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft integrity and suture placement, evidence of stromal thinning, infiltrates, perforation, graft rejection. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. Intraocular pressure is measured with pneumotonometer or Tonopen. Tip of instrument cleaned with alcohol pad. During the first of the 2 visits during this period, any remaining sutures are removed with jeweler's or McPherson forceps and disposable super sharp blade. Once the eye has dilated, a fundus examination is performed. If sutures were removed, antibiotic ophthalmic ointment is applied topically. Instructions on adjusting the doses of topical antibiotics and steroids and use of oral immune suppressives are reviewed. Slit lamp chin-rest papers are replaced.

Patient signs out and makes appointment for return visit.

**Days 61-90** (1 visit): Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding qualitative visual symptoms, postoperative pain or discharge, and use of topical and oral medications are recorded by technician. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Recommendations from consultant managing systemic immune suppression reviewed. Physician administers drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft integrity and suture placement, evidence of stromal thinning, infiltrates, perforation, graft rejection. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Intraocular pressure is measured with pneumotonometer or Tonopen. Tip of instrument cleaned with alcohol pad. Instructions on adjusting the doses of topical antibiotics and steroids and use of oral immune suppressives are reviewed. Slit lamp chin-rest papers are replaced.

Patient signs out and makes appointment for return visit.

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

---

CPT Code: 65782\_\_\_ Tracking Number: 03 Global Period: 90 Recommended RVW: 15

CPT Descriptor:

**Ocular surface reconstruction; limbal conjunctival autograft, ( includes obtaining graft) (For harvesting conjunctival allograft, living donor, see 68371)**

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey: A 27 year old with history of alkali burn of the eye with corneal and conjunctival scarring. The corneal is thinned and the surface has not reepithelialized with appropriate medical therapy.**

**Description of Pre-Service Work:**

Preoperative work begins after the decision for surgery has been made, from the day before surgery until the procedure begins. The preoperative workup, including history, physical examination and laboratory studies, are reviewed. Informed consent is obtained if not previously done. Surgical attire is donned. Necessary surgical instruments and supplies are reviewed with the operating room staff. The patient is positioned on the operating room table and the operative eye marked. Local (peribulbar or retrobulbar) or general anesthesia is administered. A surgical scrub is performed and sterile gloves and gown are donned. Prepping and draping of the surgical site is supervised.

**Description of Intra-Service Work:**

Plastic adhesive drapes are applied to both eyes, and the one over the recipient eye is incised. A lid speculum is inserted so that the lid margins and lashes are isolated from the operative field. A lateral canthotomy is performed, if necessary, to enable expansion of the lid speculum and attain adequate exposure. The operating microscope is swung into position and adjusted.

A 360-degree limbal conjunctival peritomy is performed on the recipient eye. In areas of symblepharon, conjunctival tissue is first recessed at the limbus and then undermined to allow the tissue to fall back. The symblepharon are used to reconstruct the fornix and provide epithelium for the palpebral surface. Adherent areas of conjunctiva are excised with Westcott scissors, along with a limbal skirt of subconjunctival scar tissue and Tenon's capsule. The conjunctiva is resected posteriorly 2-3 mm from the limbus for 360 degrees with Westcott scissors. Wet-field cautery, topical adrenergics, and thrombin are used to arrest bleeding from the highly vascularized field if waiting for normal clotting mechanisms does not result in adequate hemostasis. Significant bleeding may necessitate dissection of the conjunctiva one quadrant at a time.

The recipient beds are prepared for the limbal and conjunctival donor tissue by removing recipient conjunctival tissue to expose two areas of bare sclera 5-8 mm posterior to the limbus and approximately 8 mm (3 clock hours) horizontally, centered on 6 and 12 o'clock. Abnormal fibrovascular pannus and corneal epithelium are then removed from the underlying corneal stroma, using blunt dissection with cellulose surgical microsponges, followed by semi-sharp lamellar dissection with a rounded steel blade or Westcott scissors to create a smooth surface. Care is taken to maintain an anterior lamellar dissection, leaving deeper stromal layers intact. Topical adrenergics and thrombin are used to control bleeding. The surface is moistened, the speculum removed, and the lids are closed while the autografts are harvested from the fellow eye.

The plastic adhesive drape on the donor eye is incised and the speculum is placed so as to isolate the lashes and lid margins from the operative field. The operating microscope is re-centered. A Gentian violet surgical marking pen is used to mark the conjunctival borders of the grafts at 12 and 6 o'clock, with the same dimensions as the recipient beds. The conjunctiva at 12 o'clock is elevated from Tenon's layer with a subconjunctival injection of balanced salt solution or anesthetic. Radial incisions are made with Westcott scissors along the lateral borders of the grafts. Using blunt dissection, the tissue is undermined between the lateral edges, then the posterior edge is incised. The graft is reflected anteriorly over the cornea and blunt dissection is carried anteriorly to the conjunctival insertion at the limbus. A Tooke blade or other blunt scarifier is used to carry the blunt dissection further anterior into the peripheral cornea 1 mm beyond the peripheral corneal vascular arcades. The depth of the dissection is limited to a superficial epithelial keratectomy of the limbus and peripheral cornea, and does not include sclera or corneal stroma. The epitheliectomy is completed with a sharp crescent blade or Vannas

scissors. The free graft is transferred, epithelial side up, to a Petri dish and covered with corneal storage medium or balanced salt solution. The posterior conjunctiva is advanced to 2 mm posterior to the limbus and anchored to episclera with interrupted 8-0 polyglactin sutures. The same procedure is repeated at the 6 o'clock position to produce a second graft. The lid speculum is removed from the donor eye, the surface is moistened, topical antibiotic and steroid solutions are instilled, and the lids are closed.

The speculum is then placed in the recipient eye and the autografts sutured into position one at a time, with the graft limbal tissue placed at the recipient limbus. Multiple interrupted 10-0 nylon or polyglactin sutures are used, first at the corners of the graft at the limbus, then along the conjunctival portions. Viscoelastics and balanced salt solution are used to prevent dessication of the donor tissue during suturing. The suture ends are cut on the knot and rotated flush with the corneal surface. The lid speculum and drapes are removed, and the donor eye is patched with antibiotic and corticosteroid ointment, and covered with a shield.

#### **Description of Post-Service Work:**

Postoperative work begins after the patient leaves the operating room, and includes monitoring of patient stabilization; communication with family members and other health care professionals; and generation of written and oral reports of the surgery and postoperative orders in the post-anesthesia care unit. Discharge plans are written and discharge records completed, including instructions for continuing care, postoperative pain medication, topical antibiotics, and steroids. Prescriptions are written for postoperative medications.

Additionally, all post-discharge visits for this procedure for 90 days after the day of the operation are considered part of the postoperative work for this procedure. Office visits for evaluation and monitoring for development of infectious keratitis and physical integrity of the grafts are performed daily for 5 days, then twice monthly for 60 days with one additional post operative visit during the 90 day global period. Both eyes are treated with topical antibiotics and steroids four times a day until epithelialization is complete. The recipient eye also receives frequent topical preservative-free lubricants. Oral corticosteroids may be employed if significant inflammation is present in the immediate postoperative period. Sutures are removed and biweekly monitoring for inflammation and stabilization of the ocular surface is continued.

The patient is evaluated for return to normal active function at each postoperative visit. Phone calls to the patient, family, referring physician, and other health care professionals during this time period are included in the postoperative work.

#### **SURVEY DATA:**

Presenter(s)\_ Stephen Kamenetzky, M.D, Trex Topping, M.D., David Glasser, M. D.

Specialty(s): AAO, ASCRS

Sample Size: 200 Response Rate: (%): 17 Median RVW: 15

Type of Sample (Circle One): **random**, panel, convenience. Explanation of sample size:

The American Academy of Ophthalmology sent out the surveys to 200 members randomly selected. The surveyed were geographically diverse. The type of practice was varied.

25th Percentile RVW: 11.5 75th Percentile RVW: 20 Low 6.18 High: 50

Median Pre-Service Time: 60 Median Intra-Service Time: 83

25th Percentile Intra-Svc Time: 60 75th Percentile Intra-Svc Time: 90 Low: 40 High: 150

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code</u> <u>(List CPT Code &amp; # of Visits)</u>
--	-------------------	---

Immediate Post Service Time:	<u>25</u>	
------------------------------	-----------	--

Critical Care:	<u>N/A</u>	
----------------	------------	--

Other Hospital Visits:           N/A          

Discharge Day Mgmt.:           18                     ½ 99238          

Office Visits:           135                     99212 (9)          

CPT Code: 657X1

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
65750	Keratoplasty (corneal transplant); penetrating (in aphakia)	15

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

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

**TIME ESTIMATES (Median)**

<b>New/Revis.</b>	<b>Key Reference</b>
<b>CPT Code:</b>	<b>CPT Code:</b>

Median Pre-Time	60	40
Median Intra-Time	83	90
Median Immediate Post-service Time	25	20
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	18	N/A
Median of Aggregate Office Visit Times	135	138

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.21	2.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	2.83
Urgency of medical decision making	4.21	2.83

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.43	3.67
Physical effort required	4.36	3.67

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.35	3.67
Outcome depends on the skill and judgement of physician	4.43	3.67
Estimated risk of malpractice suit with poor outcome	3.93	3.33

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	4.21	3.89
Intra-Service intensity/complexity	4.29	3.78
Post-Service intensity/complexity	4.29	3.67

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

The committee chose the median for the value for this code. All of the intensity and complexity measures are significantly higher than the reference code and the median value was felt to accurately reflect the correct physician work value. The pre-service time, the immediate post service time and total post service times are significantly greater than the reference 65750. The intra service time is only slightly less.

In addition the committee reviewed some of the other codes that had recently been considered by the RUC. Code 43610 was reviewed in the August of 2000 meeting, had the same pre-service and post service time and the intra time is slightly less for our code. The post operative time is greater and the total time is comparable. The RVU for code 43610 is 14.6 and we are proposing 15. Code 35266 was reviewed at the same meeting and has similar times and an RVU of 14.91

---

**FREQUENCY INFORMATION**

How was this service previously reported? \_\_A poll of specialists found that they most commonly use 66999. Other possible codes are 65711, 68360, 68362, and 68399.

(if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty AAO \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes X Rarely

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAO \_\_\_\_\_ Frequency < 1000 \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty AAO \_\_\_\_\_ Frequency < 500 \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Do many physicians perform this service across the United States? X Yes \_\_\_\_\_ No

---

Post-op visits for 65782: Ocular surface reconstruction; limbal conjunctival autograft (includes obtaining graft)

9 level-2 visits

**Day 1:** Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding postoperative pain, discharge or bleeding, post-anesthesia reactions, use of oral analgesics recorded by technician. Tape and bandage removed. Periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers additional drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. The size of the epithelial defect is measured with the slit lamp millimeter rule and a drawing of the defect recorded. Intraocular pressure is measured with pneumotonometer or Tonopen. Tip of instrument cleaned with alcohol pad. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. The eye is patched with 1-2 eye pads and paper or plastic tape. Patient counseled on use of oral analgesics. Slit lamp chin-rest papers are replaced.

Patient signs out and follow-up appointments are made for days 2-5.

**Day 2:** Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding postoperative pain, discharge or bleeding, use of oral analgesics recorded by technician. Tape and bandage removed. Periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers additional drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus

adherent to suture ends is removed with cellulose microsponges. The size of the epithelial defect is measured with the slit lamp millimeter rule and a drawing of the defect recorded. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. The eye is patched with 1-2 eye pads and paper or plastic tape. Use of oral analgesics reviewed. Slit lamp chin-rest papers are replaced.

**Day 3:** Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding postoperative pain, discharge or bleeding, use of oral analgesics recorded by technician. Tape and bandage removed. Periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers additional drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. The size of the epithelial defect is measured with the slit lamp millimeter rule and a drawing of the defect recorded. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. The eye is patched with 1-2 eye pads and paper or plastic tape. Use of oral analgesics reviewed. Slit lamp chin-rest papers are replaced.

**Day 4:** Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding postoperative pain, discharge or bleeding, use of oral analgesics recorded by technician. Tape and bandage removed. Periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers additional drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. The size of the epithelial defect is measured with the slit lamp millimeter rule and a drawing of

the defect recorded. Intraocular pressure is measured with pneumotonometer or Tonopen. Tip of instrument cleaned with alcohol pad. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. The eye is patched with 1-2 eye pads and paper or plastic tape. Use of oral analgesics reviewed. Slit lamp chin-rest papers are replaced.

**Days 5-10** (1 visit, typically on day 5): Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding qualitative visual symptoms, postoperative pain, discharge or bleeding, use of oral medication recorded by technician. Tape and bandage removed. Periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers additional drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft integrity and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. The size of the epithelial defect, if present, is measured with the slit lamp millimeter rule and a drawing of the defect recorded. Loose sutures are removed with jeweler's or McPherson forceps and disposable super sharp blade, and any devitalized tissue at the edges of the grafts are trimmed with a Vannas scissors at the slit-lamp microscope. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. Typically, the epithelium is healed, so no patching is necessary. If an epithelial defect remains, the eye is patched with 1-2 eye pads and paper or plastic tape. Prescriptions are written for topical antibiotic and steroid drops, and the patient is instructed in frequency of application. Use of oral analgesics, if still necessary, are reviewed. Slit lamp chin-rest papers are replaced.

Patient signs out and makes appointment for return visit.

**Days 11-30** (1 visit): Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding qualitative visual symptoms, postoperative pain, discharge or bleeding, use of topical and oral medication recorded by technician. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers drop of topical anesthetic,

gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft integrity and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. If epithelium is breaking down (uncommon), lower and upper lid punctum plugs are placed. If keratolysis with threatened perforation is present (rare), cyanoacrylate glue and a therapeutic contact lens are placed. Intraocular pressure is measured with pneumotonometer or Tonopen. Tip of instrument cleaned with alcohol pad. Loose sutures are removed with jeweler's or McPherson forceps and disposable super sharp blade. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. Instructions on adjusting the doses of topical steroids and antibiotics are reviewed. Slit lamp chin-rest papers are replaced.

Patient signs out and makes appointment for return visit.

**Days 31-60** (2 visits): Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding qualitative visual symptoms, postoperative pain or discharge, and use of topical medications is recorded by technician. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers drop of topical anesthetic, drop of cycloplegic, and drop of mydriatic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft integrity and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. Intraocular pressure is measured with pneumotonometer or Tonopen. Tip of instrument cleaned with alcohol pad. During the first of the 2 visits during this period, all remaining sutures are removed with jeweler's or McPherson forceps and disposable super sharp blade. Once the eye has dilated, a fundus examination is performed. If sutures were removed, antibiotic ophthalmic ointment is applied topically. Instructions on adjusting the doses of topical antibiotics and steroids are reviewed. Slit lamp chin-rest papers are replaced.

Patient signs out and makes appointment for return visit.

**Days 61-90** (1 visit): Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding qualitative visual

symptoms, postoperative pain or discharge, and use of topical medications are recorded by technician. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for graft integrity and suture placement, evidence of stromal thinning, infiltrates, perforation. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Intraocular pressure is measured with pneumotonometer or Tonopen. Tip of instrument cleaned with alcohol pad. Instructions on adjusting the doses of topical antibiotics and steroids are reviewed. Slit lamp chin-rest papers are replaced.

Patient signs out and makes appointment for return visit.

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

---

CPT Code: 68371\_\_ Tracking Number: O4\_\_ Global Period: 10 Recommended RVW: 4.90

CPT Descriptor:

**Harvesting conjunctival allograft, living donor**

---

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: **A 45 year old with normal ocular tissue donating conjunctival tissue.**

**Description of Pre-Service Work:**

Preoperative work begins after the decision for surgery has been made, from the day before surgery until the procedure begins. The preoperative workup, including history, physical examination and laboratory studies, are reviewed. Informed consent is obtained if not previously done. Surgical attire is donned. Necessary surgical instruments and supplies are reviewed with the operating room staff. The patient is positioned on the operating room table and the operative eye marked. Topical, local (peribulbar or retrobulbar) or general anesthesia is administered. A surgical scrub is performed and sterile gloves and gown are donned. Prepping and draping of the surgical site is supervised.

**Description of Intra-Service Work:**

A plastic adhesive drape is applied to the donor eye and incised. A lid speculum is inserted so that the lid margins and lashes are isolated from the operative field. The operating microscope is swung into position and adjusted.

A Gentian violet surgical marking pen is used to mark the conjunctival borders of the donor sites at 12 and 6 o'clock. Each donor site is between 2 and 3 clock hours in length at the limbus, and extends 5 mm posterior to the limbus. The conjunctiva at 12 o'clock is elevated from Tenon's layer with a subconjunctival injection of balanced salt solution or anesthetic. Radial incisions are made with Westcott scissors along the lateral borders of the grafts. Using blunt dissection, the tissue is undermined between the lateral edges, then the posterior edge is incised. The graft is reflected anteriorly over the cornea and blunt dissection is carried anteriorly to the conjunctival insertion at the limbus. A Tooke blade or other blunt scarifier is used to carry the blunt dissection further anterior into the peripheral cornea 1 mm beyond the peripheral corneal vascular arcades. The depth of the dissection is limited to a superficial epithelial keratectomy of the limbus and peripheral cornea, and does not include sclera or corneal stroma. The epitheliectomy is completed with a sharp crescent blade or Vannas scissors. The free graft is transferred, epithelial side up, to a Petri dish and covered with corneal storage medium or balanced salt solution. The posterior conjunctiva is advanced to 2 mm posterior to the limbus and anchored to episclera with interrupted 8-0 polyglactin sutures. The same procedure is repeated at the 6 o'clock position to produce a second graft. The lid speculum is removed, topical antibiotic and steroid solutions are instilled, and the lids are closed.

**Description of Post-Service Work:**

Postoperative work begins after the patient leaves the operating room, and includes monitoring of patient stabilization; communication with family members and other health care professionals; and generation of written and oral reports of the surgery and postoperative orders in the post-anesthesia care unit. Discharge plans are written and discharge records completed, including instructions for continuing care, postoperative pain medication, topical antibiotics, and steroids. Prescriptions are written for postoperative medications.

Additionally, all post-discharge visits for this procedure for 10 days after the day of the operation are considered part of the postoperative work for this procedure. Office visits for evaluation of epithelial healing and monitoring for development of infectious keratitis are performed daily for 4 days. Topical antibiotics and steroids are instilled four times a day until epithelialization is complete, and are tapered thereafter. Sutures are removed if necessary.

The patient is evaluated for return to normal active function at each postoperative visit. Phone calls to the patient, family, referring physician, and other health care professionals during this time period are included in the postoperative work.

**SURVEY DATA:**

Presenter(s) Stephen Kamenetzky, M.D, Trex Topping, M.D., David Glasser, M. D.

Specialty(s): AAO, ASCRS

Sample Size: 200 Response Rate: (%): 17 Median RVW: 6

Type of Sample (Circle One): **random**, panel, convenience. Explanation of sample size:

The American Academy of Ophthalmology sent out the surveys to 200 members randomly selected. The surveyed were geographically diverse. The type of practice was varied.

25th Percentile RVW: 4.90 75th Percentile RVW: 7.63 Low 4.40 High: 10

Median Pre-Service Time: 30 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 37.5 Low: 10 High: 45

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code &amp; # of Visits)</u>
Immediate Post Service Time:	<u>17</u>	
Critical Care:	<u>N/A</u>	
Other Hospital Visits:	<u>N/A</u>	
Discharge Day Mgmt.:	<u>18</u>	<u>½ 99238</u>
Office Visits:	<u>60</u>	<u>99212 (4)</u>

CPT Code: 657X1

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
65870	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); anterior synechiae, except goniosynechiae	<u>6.27</u>

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

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

**TIME ESTIMATES (Median)**

	<u>New/Revis. CPT Code:</u>	<u>Key Reference CPT Code:</u>
Median Pre-Time	<u>30</u>	<u>20</u>
Median Intra-Time	<u>20</u>	<u>33</u>
Median Immediate Post-service Time	<u>17</u>	<u>32</u>

Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	18	N/A
Median of Aggregate Office Visit Times	60	80.5

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.23	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.15	2.67
Urgency of medical decision making	1.92	2.67

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.85	3.
Physical effort required	2.69	2.67

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.54	3
Outcome depends on the skill and judgement of physician	2.62	2.67
Estimated risk of malpractice suit with poor outcome	2.77	2.67

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	2.62	2.67
Intra-Service intensity/complexity	2.62	2.67
Post-Service intensity/complexity	2.23	2.67



Post-op visits for 68371: Harvesting conjunctival allograft, living donor

4 level-2 visits

**Day 1:** Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding postoperative pain, discharge or bleeding, post-anesthesia reactions, use of oral analgesics recorded by technician. Tape and bandage removed. Periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers additional drop of topical anesthetic, gives patient tissue. Ocular surface and anterior segment is examined with slit-lamp biomicroscope for evidence of corneal infiltrates. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. The size of the epithelial defect is measured with the slit lamp millimeter rule and a drawing of the defect recorded. Intraocular pressure is measured with pneumotonometer or Tonopen. Tip of instrument cleaned with alcohol pad. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. The eye is patched with 1-2 eye pads and paper or plastic tape. Patient counseled on use of oral analgesics. Slit lamp chin-rest papers are replaced.

Patient signs out and follow-up appointments are made for days 2 and 3.

**Day 2:** Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding postoperative pain, discharge or bleeding, use of oral analgesics recorded by technician. Tape and bandage removed. Periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers additional drop of topical anesthetic, gives patient tissue. Anterior segment is examined with slit-lamp biomicroscope for evidence of stromal infiltrates, thinning. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. The size of the epithelial defect is measured with the slit lamp

millimeter rule and a drawing of the defect recorded. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. The eye is patched with 1-2 eye pads and paper or plastic tape. Use of oral analgesics reviewed. Slit lamp chin-rest papers are replaced.

**Day 3:** Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding postoperative pain, discharge or bleeding, use of oral analgesics recorded by technician. Tape and bandage removed. Periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers additional drop of topical anesthetic, gives patient tissue. Ocular surface is examined with slit-lamp biomicroscope for evidence of stromal thinning, infiltrates. Fluorescein strip is moistened with irrigating solution and instilled in conjunctival cul-de-sac. Ocular surface is re-examined with slit-lamp biomicroscope after instillation of fluorescein. Mucus adherent to suture ends is removed with cellulose microsponges. If the corneal epithelium has not healed, the size of the epithelial defect is measured with the slit lamp millimeter rule and a drawing of the defect recorded. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. The eye is patched with 1-2 eye pads and paper or plastic tape. Use of oral analgesics reviewed. If the epithelium has healed, prescriptions are written for topical antibiotics and steroids and the patient is instructed in their use. Slit lamp chin-rest papers are replaced.

Patient checks out and makes appointment for return visit.

**Days 5-10** (1 visit): Patient signed in at front desk. Technician greets patient and brings back to screening lane. History regarding qualitative visual symptoms, postoperative pain, discharge or bleeding, use of oral medication recorded by technician. Tape and bandage removed, if present, and periocular area cleansed with sterile eye pad and irrigating solution. Drop of topical anesthetic administered. Visual acuity obtained with spectacles. Pinhole-assisted visual acuity obtained. Patient taken to exam lane.

Physician reviews technician workup and pursues any positive responses obtained by technician workup. Physician administers additional drop of topical anesthetic, moistens fluorescein strip with irrigating solution, and instills in conjunctival sac. Ocular surface is examined with slit-lamp biomicroscope for integrity of epithelium and conjunctiva. Mucus adherent to suture ends is removed with cellulose microsponges. Sutures are removed with jeweler's or McPherson forceps and a disposable super sharp blade at the slit-lamp

microscope. Antibiotic ophthalmic ointment is applied topically. Steroid ointment is applied topically. The epithelium is typically healed, so no patching is necessary. Prescriptions are written for topical antibiotic and steroid drops, and the patient is instructed in frequency of application and tapering. Use of oral analgesics, if still necessary, are reviewed. Slit lamp chin-rest papers are replaced.

Patient signs out and makes appointment for return visit.





AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Upper Eyelid Load Implantation**

A new CPT Code 67912 *Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)* was created to describe this procedure performed for corneal protection in cases of facial paralysis. This service has been performed for a number of years, however it has never been adequately described in CPT.

The RUC considered the survey results from nearly 30 ophthalmologists, with a survey median of 5.68. The specialty argued that the survey median did not adequately reflect the work of this service and presented a work relative value recommendation of 6.75, utilizing CPT code 67904 *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (work rvu = 6.26) as a reference service. Although the RUC agreed that the work of code 67912 was similar to 67904, the committee did not agree that it was more work. The RUC specifically did not agree with the inclusion of pre-visit, to determine the size of the weight, in the global period. This visit would typically be convened several days prior to the surgery, and therefore, it would not be appropriate to include it in the work of the service. This visit would be reported separately. Accordingly, the pre-service evaluation time was reduced from 30 minutes to 15 minutes. The RUC also determined that the post-operative visits would be more appropriate at two 99213 and one 99212, rather than three 99213 visits. The effect of removing this work from the specialty's recommendation resulted in a work relative value comparable to the survey median. **The RUC recommends a work rvu of 5.68 for CPT code 67912.**

Practice Expense

The RUC reviewed the specialty's recommended direct practice expense inputs and verified that a medium surgical instrument package was warranted and added the standard cleaning supply package. The post-operative visits were modified to be consistent with the work relative value information. The RUC agreed that the one-on-one clinical staff time with the physician intra-service time was appropriate. The RUC understands that CMS will be reviewing the issue of expensive disposable supply items to determine if these supplies should remain in the procedure code or be paid via a separate HCPCS Level II code. The specialty indicated that the gold weight is typically used. However, for patients with a gold allergy, a substitute may be utilized. The recommended direct practice expense inputs will be attached to the recommendation.

CPT Code (•New)	Track ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
•67912	GG1	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)	090	5.68

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

---

CPT Code: 67912 Tracking Number GG1 Global Period: 90 Recommended RVW **6.75**  
RUC Rec. RVW: **5.86**

CPT Descriptor:

**Correction of lagophthalmos, implantation of upper eyelid lid load (eg gold weight)**

---

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: **A 50 year old male with a permanent facial nerve palsy following resection of an ipsilateral acoustic neuroma. The patient has symptomatic exposure keratopathy, which does not respond adequately to the use of hourly topical lubricants.**

Percentage of Survey Respondents who found Vignette to be Typical: 99%

**Description of Pre-Service Work:** Final discussion with the patient and family takes place. Informed consent for the procedure is obtained. The day of surgery, the surgeon reviews the H&P and lab values. The surgeon answers any last minute family questions. Then patient co-morbidities are discussed with anesthesia. The operative consent form is reviewed and the operative eye is confirmed and marked. Once in the OR, the surgeon scrubs, gowns, and gloves. The patient is positioned, prepped, and draped. The surgeon confirms that the appropriate implant is available in the operating suite. The lid crease and the center of the lid arch are visualized, compared to the contra-lateral side, and marked. Infiltration anesthesia is administered by the surgeon. Adequate time is allowed for maximal hemostatic effect of the infiltration anesthetic.

**Description of Intra-Service Work:** A traction suture is placed through the lid margin. A lid crease incision is made. Dissection of lid structures is performed demonstrating the orbital septum and the anterior surface of the tarsus. The previously determined gold weight is centered over the bare superior tarsal surface and then sutured into position. The wound is irrigated with antibiotic solution. Orbicularis oculi muscle is closed over the implant. The traction suture is removed. Skin is closed over the orbicularis oculi muscle, including several passes through the superior border of the tarsus to restore the superior eyelid crease. Antibiotic ointment is placed over the wound and a double eye pad is applied.

**Description of Post-Service Work:** Post operative work begins in the recovery room where stabilization of the patient is assured. The post op instructions are communicated to the family. A follow up appointment for the next day is confirmed. An operative report is dictated and communication with other health professionals is provided as needed. All post-operative visits within the 90 day global period are included. Suture removal is required one week post surgery. At all visits, wound healing and evidence of implant complications such as migration, infection, or extrusion are assessed. The reanimation effect is evaluated through observation of eyelid closure and the integrity of the ocular surface. If protection of the eye is inadequate, alteration of the medical regimen and/or plans for additional procedures are made.

---

**SURVEY DATA**

<b>Presenter(s):</b> Neal Freeman, MD, Stephen Kamenetzky, M.D.					
<b>Specialty(s):</b> American Academy of Ophthalmology					
<b>CPT Code:</b> <u>67912</u>					
<b>Sample Size:</b> 100	<b>Resp n:</b> 26	<b>Resp %:</b> 26%			
<b>Sample Type:</b> Random Sample					
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	2.50	4.00	5.68	7.63	11.00
<b>Pre-Service Evaluation Time:</b>	0	16	30	28	60
<b>Pre-Service Positioning Time:</b>	2	5	5	15	20
<b>Pre-Service Scrub, Dress, Wait Time:</b>	2	10	10	15	40
<b>Intra-Service Time:</b>	5	30	40	45	90
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>15</u>				
<b>Critical Care time/visit(s):</b>	<u>N/A</u>				
<b>Other Hospital time/visit(s):</b>	<u>N/A</u>				
<b>Discharge Day Mgmt:</b>	<u>18</u>	<u>99238-1/2</u>			
<b>Office time/visit(s):</b>	<u>69-61</u>	<u>99213-2, 99212-1 99213-3</u>			

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
65101	Enucleation of eye; without implant	90	7.03

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

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

Number of respondents who choose Key Reference Code:   5  

**TIME ESTIMATES (Median)**

New/Revise. CPT Code: 67912  
 Key Reference CPT Code: 65101 (HVD)

Median Pre-Service Time	45-30	21
Median Intra-Service Time	40	56
Median Immediate Post-service Time	15	30
Median Critical Care Time	N/A	N/A
Median Other Hospital Visit Time	N/A	N/A
Median Discharge Day Management Time	NA	8.7
Median Office Visit Time	69-61	84
Median Total Time	169-146	200

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.15	3.4
--	------	-----

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.12	3.6
--	------	-----

Urgency of medical decision making	3.12	3.4
------------------------------------	------	-----

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.34	3.8
--------------------------	------	-----

Physical effort required	2.96	3.6
--------------------------	------	-----

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.88	3.2
Outcome depends on the skill and judgement of physician	3.30	3.4
Estimated risk of malpractice suit with poor outcome	2.88	3.2

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference**  
**Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.12	3.4
Intra-Service intensity/complexity	3.12	3.6
Post-Service intensity/complexity	2.84	3.4

**ADDITIONAL RATIONALE**

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

Survey participants chose a number of reference codes from a list that did not include any closely related oculoplastic codes. The AAO RUC Health Policy Committee, meeting via conference call as a consensus committee, felt that a good code for comparison to this procedure would be 67904 (Repair of blepharoptosis by levator resection or advancement, external approach).

Code 67904 (previously RUC-surveyed) was chosen by the consensus committee mainly because there are many similarities in operative technique between 67904 and 67912. For example, both 67904 and 6791X entail incisions through the eyelid crease, exposure of the tarsal plate, manipulations of the levator aponeurosis, and placement of multiple sutures through the tarsus.

Code 67904 carries a work RVU of 6.26, although RUC survey data for this code showed a median work RVU of 9.00. (The surveyed median work RVU of 9.00 could not be considered at the time of the first five-year review, because adoption of this value would have created a rank-order anomaly.)

Although survey data for 67912 showed median work RVU of 5.68, the consensus committee felt that the work RVU for 67912 should be somewhat higher than the work RVU for 67904. The work for 67912 was felt to be more than the work required for 67904 because the new procedure:

1. Requires more significant preservice work, largely consisting of the trial and error process of affixing various sizing weights so that the correct gold weight can be chosen for eventual implantation,

2. Involves centering and suturing of an external device to the tarsus (often necessitating intraoperative recentering and resuturing),
  3. Requires meticulous closure of orbicularis oculi muscle to decrease the likelihood of migration and/or extrusion of the implant, and
  4. Requires more significant postoperative work because of both the possibility of implant complications and the difficulties inherent in the management of an eye with impaired protective mechanisms.
- 
- 

### SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

**FREQUENCY INFORMATION**

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

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

Specialty ophthalmology Commonly \_\_\_\_\_ Sometimes X Rarely

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAO \_\_\_\_\_ Frequency 4000 appx

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty AAO \_\_\_\_\_ Frequency 1000 appx.

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Do many physicians perform this service across the United States? \_\_\_\_\_ Yes X No

	A	B	C	D
1				
2			67912	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Upper Eyelid Load Implantation	
4	LOCATION		In Office	Out Office
5	GLOBAL PERIOD	90		
6	TOTAL CLINICAL LABOR TIME	1121	199.0	165.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	1121	35.0	60.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	1121	65.0	6.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	1121	99.0	99.0
10	PRE-SERVICE			
11	LOCATION		In Office	Out Office
12	Start: Following visit when decision for surgery or procedure made			
13	Complete pre-service diagnostic & referral forms		5	5
14	Coordinate pre-surgery services		10	20
15	Schedule space and equipment in facility		0	8
16	Provide pre-service education/obtain consent		10	20
17	Follow-up phone calls & prescriptions		10	7
18	Other Clinical Activity (please specify)			
19	End: When patient enters office/facility for surgery/procedure			
20	SERVICE PERIOD			
21	Start: When patient enters office/facility for surgery/procedure			
22	Pre-service services			
23	Review charts		2	
24	Greet patient and provide gowning		3	
25	Obtain vital signs		3	
26	Provide pre-service education/obtain consent			
27	Prepare room, equipment, supplies		2	
28	Prepare and position patient/ monitor patient/ set up IV		2	
29	Sedate/apply anesthesia			
30	Intra-service			
31	Assist physician in performing procedure		40	
32	Post-Service			
33	Monitor pt following service/check tubes, monitors, drains		5	
34	Clean room/equipment by physician staff		3	
35	Clean Scope			
36	Complete diagnostic forms, lab & X-ray requisitions			
37	Review/read X-ray, lab, and pathology reports			
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions		5	
39	Discharge day management 99238 --12 minutes 99239 --15 minutes			6
40	Other Clinical Activity (please specify)			
41	End: Patient leaves office			
42	POST-SERVICE Period			
43	Start: Patient leaves office/facility			
44	Clean surgical medium tray		15	
45	Conduct phone calls/call in prescriptions			0
46	Office visits Greet patient, escort to room, provide gowning, interval history & vital signs and chart, assemble previous test reports/results, assist physician during exam, assist with dressings, wound care, suture removal, prepare dx test, prescription forms, post service education, instruction, counseling, clean room/equip, check supplies, coordinate home or outpatient care			
47	List Number and Level of Office Visits			
48	99211 16 minutes	16		
49	99212 27 minutes	27	1	1
50	99213 36 minutes	36	2	2
51	99214 53 minutes	53		
52	99215 63 minutes	63		
53	Other			
54				
55	Total Office Visit Time		99	99
56	Other Activity (please specify)			
57	End: with last office visit before end of global period			

	A	B	C	D
2			67912	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Upper Eyelid Load Implantation	
4	LOCATION		In Office	Out Office
58	<b>MEDICAL SUPPLIES</b>			
59	PEAC multispecialty supply package	pkg	1	
60	Post-op incision care kit	pkg	1	1
61	Ophthalmology visit package, non dilated	pkg	4	3
62	sterile gown	14008	2	
63	sterile gloves	14005	2	
64	sterile cap	11305	2	
65	sterile mask	11301	2	
66	sterile shoe covers	new	2	
67	sterile drape sheet	14001	1	
68	4x4's (10/lpack)	31508	1	
69	suture nylon 6 inch	31701	1	
70	suture vicryl 5 inch	new	1	
71	suture vicryl 6 inch	new	1	
72	cotton applicators	31103	10	
73	gold lid load/ 1 2 gram \$215 00 IOP California	NEW	1	
74	syringe 5cc	91411	1	
75	needle 20gauge	new	1	
76	needle 27 gauge	new	1	
77	blade #15	new	1	
78	medium sugical instrument pack cleaning supplies package	new	1	
79	xylocaine 1% c epinephrine(cc)	51503	5	
80	<b>Equipment</b>			
81	Screening Lane	E71111	4	3
82	medium surgical instrument pack	new	1	
83	cautery, including tip & cord	unlisted	1	

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Intra-operative MRI**

The CPT Editorial Panel created three new codes to describe new procedures and new technology (use of MRI during an operation to evaluate tumor in the brain during resection) which plays an increasingly important role in the treatment of patients with intracranial lesions, including neoplasm and skull base tumors. The existing MRI codes 70551, 70552 and 70553 describe the “radiologic supervision and interpretation” of the brain and do not reflect the intra-operative time and effort involved in repeated image acquisition in real-time under stereotactic guidance and the intra-operative interpretation of the images which occurs sequentially throughout these new procedures.

70557

The RUC examined code 70557 *Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material*. The RUC began by discussing the survey data acquired by the specialty society due to the small number of surveys and the wide variation of times reported. Therefore, the RUC began to review the work RVU interval between the reference code 70551 *Magnetic resonance (eg proton) imaging chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)* (Work RVU = 1.48) and 70552 *Magnetic resonance (eg proton) imaging chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences*; (Work RVU = 1.78).

$$\begin{array}{r} \text{Work RVU of 70552} \\ (1.78) \end{array} - \begin{array}{r} \text{Work RVU of 70551} \\ (1.48) \end{array} = \begin{array}{r} \text{Interval} \\ (0.30) \end{array}$$

The RUC felt that this interval could appropriately be applied between 70557 and 70558 *Magnetic resonance (eg Proton) imaging chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)*. The RUC had accepted a work RVU recommendation of 3.20 for this code.

$$\begin{array}{r} \text{Work RVU of 70558} \\ (3.20) \end{array} - \begin{array}{r} \text{Interval} \\ (0.30) \end{array} = \begin{array}{r} \text{Work RVU of 70557} \\ (2.90) \end{array}$$

**The RUC agrees that this rationale is appropriate and recommends a relative work RVU of 2.90 for CPT code 70557.**

### 70558

The RUC examined code 70558 *Magnetic resonance (eg Proton) imaging chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)*. After reviewing the reference code 70552 *Magnetic resonance imaging; brain (including brain stem); with contrast material* (Work RVU = 1.78), the RUC determined that the reference code has a Harvard total time of 33 minutes as compared to the surveyed code with a total time of 195 minutes. In addition, the surveyed code was considered to be significantly more intense than 70552. However, the specialty society felt that because this reference code was selected by only twenty-five percent of the respondents that this data should further be examined by an expert consensus panel. The panel determined that 76394 *Magnetic resonance guidance for, and monitoring of tissue ablation* (Work RVU = 4.25) is an appropriate reference service. The RUC recognized that the median intra-service time obtained in the surveys for 70558 is 120 minutes and is 73% of the intra-service time for 76394 (intra-service time = 165 minutes). Seventy-three percent of the physician work value of 76394 is approximately 3.2 RVUs. **Therefore, the RUC recommends a work RVU of 3.2 for 70558.**

### 70559

The RUC examined code 70559 *Magnetic resonance (eg Proton) imaging chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material, followed by contrast material(s) and further sequences*. After reviewing the reference code 70553 *Magnetic resonance imaging; brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences* (Work RVU = 2.36), the RUC determined that the reference code has a Harvard total time of 43 minutes as compared to the surveyed code with a total time of 195 minutes. In addition, the surveyed code was considered to be significantly more intense than 70553. However, the specialty society felt that because this reference code was selected by only twenty-five percent of the respondents that this data should further be examined by an expert consensus panel. The panel determined that 76394 *Magnetic resonance guidance for, and monitoring of tissue ablation* (Work RVU = 4.25) is an appropriate reference service. The RUC recognized that the median intra-service time obtained in the surveys for 70559 is 120 minutes and is 73% of the intra-service time for 76394 (intra-service time = 165 minutes). Seventy-three percent of the physician work value of 76394 is approximately 3.2 RVUs. In addition, the specialty society's survey results indicated no difference in intra-service time between the 70559 and 70558 and therefore the RUC felt that establishing the same physician work value for both seemed appropriate. **Therefore to account for the survey results and the results of the consensus panel, the RUC recommends a work RVU of 3.2 for 70558.**

### Practice Expense

There are no practice expense inputs recommended for these codes.

CPT Code (●New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
●70557	P1	Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material	XXX	2.9
●70558	P2	with contrast material(s)	XXX	3.2
●70559	P3	without contrast material, followed by contrast materials(s) and further sequences  <u>(For stereotactic biopsy of intracranial lesion with magnetic resonance guidance, use 61751. Code 70557, 70558 or 70559 may be reported only if a separate report is generated. Report only one of the above codes once per operative session. Do not use these codes with 61751, 76393, 76394)</u>	XXX	3.2

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

CPT Code: 70557 Tracking Number: P1 Global Period: XXX **Recommended RVW: 3.2**  
**RUC Recommended RVW: 2.90**

**CPT Descriptor: Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material**

**(For stereotactic biopsy of intracranial lesion with magnetic resonance guidance, use 61751. Code 70557, 70558 or 70559 may be reported only if a separate report is generated. Report only one of the above codes once per operative session. Do not use these codes with 61751, 76393, 76394)**

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 40 year old right handed male with a new onset tonic-clonic seizures associated with postictal aphasia and right hemiparesis was found to have a well-circumscribed mass in his left fronto-temporal (insular) region. Previous biopsy demonstrated an oligodendroglioma. The neurosurgeon has recommended complete resection of the tumor using intraoperative MRI (iMRI) for guidance. From review of preoperative studies, it was determined complete resection can be accomplished without IV contrast. During the surgical procedure the appropriate MRI scan sequences are performed and interpreted to evaluate and facilitate the optimal resection of the tumor with the interpretation communicated to the surgeon during the surgical procedure.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

**Description of Pre-Service Work:**

- Review of all previous imaging studies with emphasis on the signal and enhancements characteristics of the lesion necessary to plan intraoperative MRI (iMRI)
- Consult with the operating surgeon and select the appropriate sequences and imaging planes.

**Description of Intra-Service Work:**

- Supervision and interpretation of preliminary scans
- Following intraoperative determination of eloquent cortex, supervision and interpretation of iMRI sequences designed to determine the relation of the lesion to the eloquent cortex
- Following operative exposure of the lesion, supervision and interpretation of iMRI sequences designed to re-evaluate the relation of the lesion to the eloquent cortex by comparison to the previous images and determination of potential shifts that may have occurred during exposure
- Following operative resection of all visible tumor, supervision and interpretation of iMRI sequences designed to assess the adequacy of tumor resection and determination of whether any residual gross tumor is present
- Supervision and interpretation of all additional iMRI sequences designed to reassess the adequacy of tumor resection and determination of whether any residual tumor is present following additional resections of tumor identified on iMRI sequences including those sequences obtained in the operating room at the end of the surgical procedure
- Intraservice work includes all communications between interpreting physician and operating physician that occur during the procedure.

**Description of Post-Service Work:**

- Dictate report of the iMRI examination
- Review and sign report
- Additional discussion with operating physicians and family

**SURVEY DATA**

<b>Presenter(s):</b>	Robert Barr, MD, Bibb Allen, Jr., MD, Jeffrey Cozzens, MD, FACS,				
<b>Specialty(s):</b>	American Society of Neuroradiology (ASNR), American College of Radiology (ACR), American Association of Neurological Surgeons (AANS)/Congress of Neurological Surgeons (CNS)				
<b>CPT Code:</b>	70557				
<b>Sample Size:</b> 25	<b>Resp n:</b> 8	<b>Resp %:</b> 32%			
<b>Sample Type:</b> panel					
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.6	3.26	5	5.8	5.8
<b>Pre-Service Evaluation Time:</b>	10	19	30	60	60
<b>Pre-Service Positioning Time:</b>	-	-	-	-	-
<b>Pre-Service Scrub, Dress, Wait Time:</b>	-	-	-	-	-
<b>Intra-Service Time:</b>	20	34	120	120	240
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15	N/A			
<b>Critical Care time/visit(s):</b>	N/A				
<b>Other Hospital time/visit(s):</b>	N/A				
<b>Discharge Day Mgmt:</b>	N/A				
<b>Office time/visit(s):</b>	N/A				

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

CPT Code 70551      CPT Descriptor : Magnetic resonance imaging, brain (including brain stem); without contrast material

Global XXX      Work RVU 1.48

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

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

Number of respondents who choose Key Reference Code: 25% \_\_\_\_\_

**TIME ESTIMATES (Median)**

	New/Revis. CPT Code:	Key Reference CPT Code:
Median Pre-Service Time	60	28/pr - total time from RUC database
Median Intra-Service Time	120	N/A
Median Immediate Post-service Time	15	N/A
Median Critical Care Time	N/A	N/A
Median Other Hospital Visit Time	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median Office Visit Time	N/A	N/A
<b>Median Total Time</b>	<b>195</b>	<b>N/A</b>

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.6	2.6
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.8	2.8
Urgency of medical decision making	4.0	2.8

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.2	3.3
Physical effort required	4.1	2.2

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.0	3.2
Outcome depends on the skill and judgement of physician	4.3	3.5
Estimated risk of malpractice suit with poor outcome	3.7	3.2

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	4.1	2.8
Intra-Service intensity/complexity	3.7	2.8
Post-Service intensity/complexity	3.0	2.6

**ADDITIONAL RATIONALE**

Representatives of AANS, ASNR, and ACR discussed the results of the survey. Because of the small number of surveys and the wide variation in times reported, a consensus panel was convened to discuss the data. The panel recognized the limitations of the survey data but concluded that the results were to some extent reflective of the disparate practice patterns for the procedure. The panel also felt that the reliability of the survey data was not likely to be improved by repeat survey in the near future because the procedure, though fairly "mature" in its evolution, is performed at so few institutions.

The panel considered the following XXX codes that have been RUC surveyed as comparisons:

CODE	PRE	INTRA	POST	wRVU	
70557-3	30	120	30		
95810	15	60	20	3.53	polysomnography
99235	10	75	15	3.42	Inpt hosp care
99291	15	45	15	4.00	Critical care 1hr
76394	20	165	15	4.25	MR liver ablation
70546	6	15	10	1.8	MRA s/c
70553		Hvd 43 total	2.36		MRI head s/c

Using these codes, an initial range for iMRI valuation was felt to lie between 2.36 and 4.25.

The panel determined that 76394 (Magnetic resonance guidance for, and monitoring of tissue ablation) is an appropriate reference service. It has an intraservice time of 165 minutes, similar pre- and post-service times and was recently valued by the RUC at 4.25. The median intraservice time obtained in the surveys for iMRI is 120 minutes and is 73% of the intraservice time for 76394. 73% of the physician work value of 76394 is 3.1 RVU. This is comparable to the 25th% RVU for iMRI without contrast of 3.26. The surveys indicate no difference in intraservice time between the three iMRI codes and establishing a physician work value of 3.2 for all the

codes in this family was felt appropriate. Therefore we are recommending a work RVU of 3.2.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

3. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes.

	CPT	global	multi	RVW	Pre	Intra	Post	Total
1.	70557	XXX	100%	3.2	30	120	30	180
2.	61750	090	100%	18.20	35	133	222	390 Harvard
3.	61795	ZZZ	100%	4.04	N/A	N/A	N/A	97/pr
4.	69990	ZZZ	100%	3.47	N/A	N/A	N/A	N/A

---

**FREQUENCY INFORMATION**

How was this service previously reported? 76499 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty: Neurosurgery (AANS) Commonly Sometimes X Rarely

Specialty: Radiology (ACR)/(ASNR) Commonly Sometimes X Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AANS Frequency 75

Specialty ACR/ASNR Frequency 75

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

Specialty AANS Frequency 25

Specialty ACR/ASNR Frequency 25

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

---

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

---

CPT Code: 70558 Tracking Number: P2 Global Period: XXX Recommended RVW: 3.2

**CPT Descriptor: Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); with contrast material**

**(For stereotactic biopsy of intracranial lesion with magnetic resonance guidance, use 61751. Code 70557, 70558 or 70559 may be reported only if a separate report is generated. Report only one of the above codes once per operative session. Do not use these codes with 61751, 76393, 76394)**

---

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: : 40 year old right handed male with a new onset tonic-clonic seizures associated with postictal aphasia and right hemiparesis was found to have a well-circumscribed mass in his left fronto-temporal (insular) region. Previous biopsy demonstrated an oligodendroglioma. The operating surgeon has recommended complete resection of the tumor using intraoperative MRI (iMRI) for guidance. From review of preoperative studies, it was determined that IV contrast will be necessary for assuring complete resection, but no nonenhanced scans are required. During the surgical procedure the appropriate MRI scan sequences are performed and interpreted to evaluate and facilitate the optimal resection of the tumor with the interpretation communicated to the surgeon during the surgical procedure.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

**Description of Pre-Service Work:**

- Obtain additional informed consent for intravenous contrast
- Review of all previous imaging studies with emphasis on the signal and enhancements characteristics of the lesion necessary to plan intraoperative MRI (iMRI)
- Consult with the operating surgeon and select the appropriate sequences and imaging planes.

**Description of Intra-Service Work:**

- Supervision and interpretation of precontrast scans
- Following intraoperative determination of eloquent cortex, supervision and interpretation contrast enhanced iMRI sequences designed to determine the relation of the lesion to the eloquent cortex
- Following operative exposure of the lesion, supervision and interpretation of contrast enhanced iMRI sequences designed to re-evaluate the relation of the lesion to the eloquent cortex by comparison to the previous images and determination of potential shifts that may have occurred during exposure
- Following operative resection of all visible tumor, supervision and interpretation of contrast enhanced iMRI sequences designed to assess the adequacy of tumor resection and determination of whether any residual gross tumor is present
- Supervision and interpretation of all additional iMRI sequences designed to reassess the adequacy of tumor resection and determination of whether any residual tumor is present following additional resections of tumor identified on iMRI sequences including those sequences obtained in the operating room at the end of the surgical procedure
- Intraservice work includes all communications between interpreting physician and operating physician that occur during the procedure.

**Description of Post-Service Work:**

- Dictate report of the iMRI examination
- Review and sign report
- Additional discussion with operating physicians and family

**SURVEY DATA**

<b>Presenter(s):</b>	Robert Barr, MD, Jeffrey Cozzens, MD, FACS, Bibb Allen, Jr., MD				
<b>Specialty(s):</b>	American Society of Neuroradiology (ASNR), American Association of Neurological Surgeons (AANS), and American College of Radiology (ACR)				
<b>CPT Code:</b>	70558				
<b>Sample Size:</b> 25	<b>Resp n:</b> 8	<b>Resp %:</b> 32%			
<b>Sample Type:</b> panel					
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.79	3.44	5	8.6	8.6
<b>Pre-Service Evaluation Time:</b>	10	16	30	60	60
<b>Pre-Service Positioning Time:</b>			-		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			-		
<b>Intra-Service Time:</b>	20	30	120	120	240
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15	N/A			
<b>Critical Care time/visit(s):</b>	N/A				
<b>Other Hospital time/visit(s):</b>	N/A				
<b>Discharge Day Mgmt:</b>	N/A				
<b>Office time/visit(s):</b>	N/A				

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

CPT Code 70552      CPT Descriptor : Magnetic resonance imaging, brain (including brain stem); with contrast material.

Global XXX      Work RVU 1.78

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

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

Number of respondents who choose Key Reference Code: 25%

**TIME ESTIMATES (Median)**

	<u>New/Revis.</u> <u>CPT Code:</u>	<u>Key Reference</u> <u>CPT Code:</u>
Median Pre-Service Time	60	33/pr - total time from RUC database
Median Intra-Service Time	120	N/A
Median Immediate Post-service Time	15	N/A
Median Critical Care Time	N/A	N/A
Median Other Hospital Visit Time	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median Office Visit Time	N/A	N/A
<b>Median Total Time</b>	<b>195</b>	<b>N/A</b>

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.7	2.8
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.8	2.7
Urgency of medical decision making	4.0	3.0

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.6	3.3
Physical effort required	3.8	2.6

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.0	3.2
Outcome depends on the skill and judgement of physician	4.3	3.5
Estimated risk of malpractice suit with poor outcome	3.7	3.2

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference  
Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	4.1	2.8
Intra-Service intensity/complexity	4.3	3.0
Post-Service intensity/complexity	2.8	2.6

**ADDITIONAL RATIONALE**

Representatives of AANS, ASNR, and ACR discussed the results of the survey. Because of the small number of surveys and the wide variation in times reported, a consensus panel was convened to discuss the data. The panel recognized the limitations of the survey data but concluded that the results were to some extent reflective of the disparate practice patterns for the procedure. The panel also felt that the reliability of the survey data was not likely to be improved by repeat survey in the near future because the procedure, though fairly "mature" in its evolution, is performed at so few institutions.

The panel considered the following XXX codes that have been RUC surveyed as comparisons:

CODE	PRE	INTRA	POST	wRVU	
70557-3	30	120	30		
95810	15	60	20	3.53	polysomnography
99235	10	75	15	3.42	Inpt hosp care
99291	15	45	15	4.00	Critical care 1hr
76394	20	165	15	4.25	MR liver ablation
70546	6	15	10	1.8	MRA s/c
70553		Hvd 43 total	2.36		MRI head s/c

Using these codes, an initial range for iMRI valuation was felt to lie between 2.36 and 4.25.

The panel determined that 76394 (Magnetic resonance guidance for, and monitoring of tissue ablation) is an appropriate reference service. It has an intraservice time of 165 minutes, similar pre- and post-service times and was recently valued by the RUC at 4.25. The median intraservice time obtained in the surveys for iMRI is 120 minutes and is 73% of the intraservice time for 76394. 73% of the physician work value of 76394 is 3.1 RVU. This is comparable to the 25th% RVU for iMRI without contrast of 3.26. The surveys indicate no difference in intraservice time between the three iMRI codes and establishing a physician work value of 3.2 for all the

codes in this family was felt appropriate. Therefore we are recommending a work RVU of 3.2.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

	CPT	global	multi	RVW	Pre	Intra	Post	Total
1.	70557	XXX	100%	3.2	30	120	30	180
2.	61750	090	100%	18.20	35	133	222	390 Harvard
3.	61795	ZZZ	100%	4.04	N/A	N/A	N/A	97/pr
4.	69990	ZZZ	100%	3.47	N/A	N/A	N/A	N/A

---

**FREQUENCY INFORMATION**

How was this service previously reported? \_\_\_\_\_ 76499 \_\_\_\_\_ (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty: Neurosurgery (AANS) \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_X\_\_\_ Rarely

Specialty: Radiology (ACR)/(ASNR) \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_X\_\_\_ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty \_\_\_\_\_ AANS \_\_\_\_\_ Frequency \_\_\_\_\_ 75 \_\_\_\_\_

Specialty \_\_\_\_\_ ACR/ASNR \_\_\_\_\_ Frequency \_\_\_\_\_ 75 \_\_\_\_\_

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

Specialty \_\_\_\_\_ AANS \_\_\_\_\_ Frequency \_\_\_\_\_ 25 \_\_\_\_\_

Specialty \_\_\_\_\_ ACR/ASNR \_\_\_\_\_ Frequency \_\_\_\_\_ 25 \_\_\_\_\_

Do many physicians perform this service across the United States? \_\_\_\_\_ Yes \_\_\_X\_\_\_ No

---

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

---

CPT Code: 70559 Tracking Number: P3 Global Period: XXX Recommended RVW: 3.2

CPT Descriptor: **Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material, followed by contrast material(s) and further sequences**

**(For stereotactic biopsy of intracranial lesion with magnetic resonance guidance, use 61751. Code 70557, 70558 or 70559 may be reported only if a separate report is generated. Report only one of the above codes once per operative session. Do not use these codes with 61751, 76393, 76394)**

---

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: : 40 year old right handed male with a new onset tonic-clonic seizures associated with postictal aphasia and right hemiparesis was found to have a well-circumscribed mass in his left fronto-temporal (insular) region. Previous biopsy demonstrated an oligodendroglioma. The operating surgeon has recommended complete resection of the tumor using intraoperative MRI (iMRI) for guidance. From review of preoperative studies, it was determined complete resection will require the use of both nonenhanced and contrast enhanced scans. During the surgical procedure the appropriate MRI scan sequences are performed and interpreted to evaluate and facilitate the optimal resection of the tumor with the interpretation communicated to the surgeon during the surgical procedure

Percentage of Survey Respondents who found Vignette to be Typical: 100%

**Description of Pre-Service Work:**

- Obtain additional informed consent for intravenous contrast
- Review of all previous imaging studies with emphasis on the signal and enhancements characteristics of the lesion necessary to plan intraoperative MRI (iMRI)
- Consult with the operating surgeon and select the appropriate sequences and imaging planes.

**Description of Intra-Service Work:**

- Supervision and interpretation of precontrast scans.
- Following intraoperative determination of eloquent cortex, supervision and interpretation of contrast enhanced iMRI sequences designed to determine the relation of the lesion to the eloquent cortex
- Following operative exposure of the lesion, supervision and interpretation of contrast enhanced iMRI sequences designed to re-evaluate the relation of the lesion to the eloquent cortex by comparison to the previous images and determination of potential shifts that may have occurred during exposure
- Following operative resection of all visible tumor, supervision and interpretation of contrast enhanced iMRI sequences designed to assess the adequacy of tumor resection and determination of whether any residual gross tumor is present
- Supervision and interpretation of all additional iMRI sequences designed to reassess the adequacy of tumor resection and determination of whether any residual tumor is present following additional resections of tumor identified on iMRI sequences including those sequences obtained in the operating room at the end of the surgical procedure
- Intraservice work includes all communications between interpreting physician and operating physician that occur during the procedure.

**Description of Post-Service Work:**

- Dictate report of the iMRI examination
- Review and sign report
- Additional discussion with operating physicians and family

**SURVEY DATA**

<b>Presenter(s):</b>	Robert Barr, MD, Jeffrey Cozzens, MD, FACS, Bibb Allen, Jr., MD				
<b>Specialty(s):</b>	American Society of Neuroradiology (ASNR), American Association of Neurological Surgeons (AANS), and American College of Radiology (ACR)				
<b>CPT Code:</b>	70559				
<b>Sample Size:</b> 25	<b>Resp n:</b> 8	<b>Resp %:</b> 32%			
<b>Sample Type:</b> panel					
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	2.41	3.84	5.25	6.2	6.2
<b>Pre-Service Evaluation Time:</b>	10	20	30	60	60
<b>Pre-Service Positioning Time:</b>			-		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			-		
<b>Intra-Service Time:</b>	25	37	120	120	240
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	15	N/A			
<b>Critical Care time/visit(s):</b>	N/A				
<b>Other Hospital time/visit(s):</b>	N/A				
<b>Discharge Day Mgmt:</b>	N/A				
<b>Office time/visit(s):</b>	N/A				

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

CPT Code 70553      CPT Descriptor : Magnetic resonance imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences  
Global XXX      Work RVU 2.36

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

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

Number of respondents who choose Key Reference Code: 25%\_\_\_\_\_

**TIME ESTIMATES (Median)**

	<u>New/Revis.</u> <u>CPT Code:</u>	<u>Key Reference</u> <u>CPT Code:</u>
Median Pre-Service Time	60	43/pr - total time from RUC database
Median Intra-Service Time	120	N/A
Median Immediate Post-service Time	15	N/A
Median Critical Care Time	N/A	N/A
Median Other Hospital Visit Time	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median Office Visit Time	N/A	N/A
<b>Median Total Time</b>	<b>195</b>	<b>N/A</b>

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.7	3.0
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.8	2.8
Urgency of medical decision making	4.0	2.5

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.0	3.5
Physical effort required	4.0	3.0

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.3	3.1
Outcome depends on the skill and judgement of physician	4.1	3.3
Estimated risk of malpractice suit with poor outcome	3.6	3.6

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	4.1	3.1
Intra-Service intensity/complexity	4.3	3.1
Post-Service intensity/complexity	3.1	3.0

**ADDITIONAL RATIONALE**

Representatives of AANS, ASNR, and ACR discussed the results of the survey. Because of the small number of surveys and the wide variation in times reported, a consensus panel was convened to discuss the data. The panel recognized the limitations of the survey data but concluded that the results were to some extent reflective of the disparate practice patterns for the procedure. The panel also felt that the reliability of the survey data was not likely to be improved by repeat survey in the near future because the procedure, though fairly "mature" in its evolution, is performed at so few institutions.

The panel considered the following XXX codes that have been RUC surveyed as comparisons:

CODE	PRE	INTRA	POST	wRVU	
70557-3	30	120	30		
95810	15	60	20	3.53	polysomnography
99235	10	75	15	3.42	Inpt hosp care
99291	15	45	15	4.00	Critical care 1hr
76394	20	165	15	4.25	MR liver ablation
70546	6	15	10	1.8	MRA s/c
70553		Hvd 43 total	2.36		MRI head s/c

Using these codes, an initial range for iMRI valuation was felt to lie between 2.36 and 4.25.

The panel determined that 76394 (Magnetic resonance guidance for, and monitoring of tissue ablation) is an appropriate reference service. It has an intraservice time of 165 minutes, similar pre- and post-service times and was recently valued by the RUC at 4.25. The median intraservice time obtained in the surveys for iMRI is 120 minutes and is 73% of the intraservice time for 76394. 73% of the physician work value of 76394 is 3.1 RVU. This is comparable to the 25th% RVU for iMRI without contrast of 3.26. The surveys indicate no difference in intraservice time between the three iMRI codes and establishing a physician work value of 3.2 for all the

codes in this family was felt appropriate. Therefore we are recommending a work RVU of 3.2.

---



---

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

	CPT	global	multi	RVW	Pre	Intra	Post	Total
1.	70557	XXX	100%	3.2	30	120	30	180
2.	61750	090	100%	18.20	35	133	222	390 Harvard
3.	61795	ZZZ	100%	4.04	N/A	N/A	N/A	97/pr
4.	69990	ZZZ	100%	3.47	N/A	N/A	N/A	N/A

---

---

**FREQUENCY INFORMATION**

How was this service previously reported? 76499 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty: Neurosurgery (AANS)       Commonly       Sometimes       Rarely

Specialty: Radiology (ACR)/(ASNR)       Commonly       Sometimes       Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AANS      Frequency 75

Specialty ACR/ASNR      Frequency 75

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

Specialty AANS      Frequency 25

Specialty ACR/ASNR      Frequency 25

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

---

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Corneal Pachymetry Echography**

The CPT Editorial Panel created a new code 76514 *Ophthalmic ultrasound, echography, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)* to describe the measurement of corneal thickness. This service may be performed for patients who are candidates for corneal transplantation, as well as patients with glaucoma. Peer-reviewed literature has recently supported the importance of measuring corneal thickness in glaucoma patients. The incidence of glaucoma in the general population is 1 to 2 percent. The specialty indicated that most glaucoma patients may expect to receive this service once, while those with corneal disease may have the measurement completed on more than one occasion. The specialty also indicated that the utilization of these services will be higher in the first year or two of the code's release, as there will be a general catch up in measuring all glaucoma patients. After this initial period, it is expected that the test will only be performed on newly diagnosed glaucoma patients.

A survey of more than 30 ophthalmologists indicated that this service is similar in work to CPT code 92083 *Visual field examination, unilateral or bilateral, with interpretation and report* (work rvu = 0.50). However, the specialty determined that this service was more comparable to 76076 *Dual energy x-ray absorptiometry (DEXA) bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)* (work rvu = 0.22); 71010 *Radiologic examination, chest; single view, frontal* (work rvu = 0.18); 93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report* (work rvu = 0.17); or 99211 *Established patient office visit, level one* (work rvu = 0.17).

The RUC reviewed the activities performed by the technician versus the physician. The specialty indicated that in some practices the physician will actually perform the measurement, while in others a technician would perform the measurement and the physician would then interpret the findings. The specialty stated that "the applanation of the central cornea could be done by a technician but typically will be performed by a physician. If the readings are taken by the technician rather than the physician, the physician still must establish the validity and import of the findings. The physician must address the following issues: If the corneal readings are thin, does the increased "true" pressure constitute a risk to the patient? If the difference in the applanation and corrected pressure using pachymetry significant enough to change the observation or management of the patient?" The RUC concurred that a small amount of physician work is appropriate as this test may modify another test and physician interpretation is necessary. The specialty

also indicated that the medical record will include a written note from the physician, which includes the thickness and the impact on measurements of the intraocular pressure (IOP). An example of this note is attached to this recommendation.

The RUC also requested that the CPT Editorial Panel clarify that this code should be reported for either unilateral or bilateral measurements. The CPT Editorial Panel has modified the nomenclature to provide this clarification.

Practice Expense

The RUC clarified that this service is typically provided on the same date as an eye exam code or evaluation and management service. Therefore, there are minimal practice expense inputs associated with this service. Either the equipment must be moved into the patient or the patient is moved to the equipment. The RUC, therefore, thought the total clinical staff time of 5 minutes was reasonable. There are no medical supplies associated with this service. The only equipment is the ultrasonic pachymeter.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<del>0025T</del>		<del>0025T Determination of corneal thickness (eg, pachymetry) with interpretation and report, bilateral</del> (0025T has been deleted. To report, use 76514)	XXX	N/A
•76514	HH1	Ophthalmic ultrasound, echography, diagnostic; corneal pachymetry ), unilateral or bilateral (determination of corneal thickness	XXX	0.17

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS

## SUMMARY OF RECOMMENDATION

CPT Code: 7651X Tracking Number: HH1 Global Period: XXX Recommended RVW: 0.17CPT Descriptor: **Ophthalmic ultrasound, echography, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)****CLINICAL DESCRIPTION OF SERVICE:****Vignette Used in Survey:**

A 50 year old patient is found to have an apparent increased intraocular pressure (IOP). A measurement of 26 mm Hg was detected by applanation tonometry during an ophthalmic exam. There was no family history of glaucoma and the optic nerves appeared healthy. A measurement of corneal thickness was requested to adjust or normalize the measured pressure.

Percentage of Survey Respondents who found Vignette to be Typical: **99%****Description of Pre-Service Work:**

A brief description on the nature of the test is presented to the patient. The patient is taken to an exam room, seated in an exam chair, and the eye to be examined is pretreated with a topical anesthetic.

**Description of Intra-Service Work:**

The patient is instructed to fixate on a distant target in order to stabilize the globe. The ultrasound probe is aligned with the center of the cornea and then brought into contact with the center of the cornea. Five consecutive readings are obtained. The high and low readings are discarded and an average thickness measurement in microns determined for the eye being tested. The physician interprets the effect of the corneal thickness on intraocular measurements.

**Description of Post-Service Work:** A specific comment is reported in the medical record including the thickness and the impact on measurements of IOP. This measure will be used to adjust future measurements of IOP.

**SURVEY DATA**

Presenter(s):	Ruth Williams, M.D., Stephen Kamenetzky, M.D.				
Specialty(s):	American Academy of Ophthalmology				
CPT Code:	<u>76514</u>				
Sample Size: 100	Resp n: 31	Resp %: 31%			
Sample Type: Random sample					
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
Survey RVW:	.35	.4	.5	.5	1.72
Pre-Service Evaluation Time:	1	2.5	5	8.75	15
Intra Time:	2	2	5	10	40
Immed Post-Time:	1	3	5	10	20
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
Critical Care time/visit(s):	<u>N/A</u>				
Other Hospital time/visit(s):	<u>N/A</u>				
Discharge Day Mgmt:	<u>N/A</u>				
Office time/visit(s):	<u>N/A</u>				

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
92083	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30°, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)		0.50 XXX

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

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

Number of respondents who choose Key Reference Code: 27

**TIME ESTIMATES (Median)**

New/Revis. CPT Code: 76514      Key Reference CPT Code: 92083

Median Pre-Service Time	5	
Median Intra-Service Time	5	
Median Immediate Post-service Time	5	
Median Critical Care Time	N/A	
Median Other Hospital Visit Time	N/A	
Median Discharge Day Management Time	N/A	
Median Office Visit Time	N/A	
Median Total Time	15	17 (Harvard)

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.5	3.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.59	3.0
Urgency of medical decision making	2.44	2.78

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.56	2.59
Physical effort required	2.09	1.93

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.0	1.81
Outcome depends on the skill and judgement of physician	2.75	2.96
Estimated risk of malpractice suit with poor outcome	2.34	2.59

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	1.97	2.12
Intra-Service intensity/complexity	2.55	2.63
Post-Service intensity/complexity	2.66	2.68

**ADDITIONAL RATIONALE**

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

The survey participants chose reference code 92083, the most similar code on the Reference Service list provided. The AAO Health Planning Committee met via conference call and, acting consensus committee, felt that the value determined from the reference code was too high because of the large difference in intra-service time between the surveyed code and the reference service. In addition, the consensus committee felt that because ophthalmology has not previously surveyed a diagnostic code that did not require the "interpretation and report" the surveyees estimates of pre, intra and post time were distorted by their confusion as to what is done is an accompanying EM service and what is done during the test itself. The consensus committee chose 76076 (DEXA bone density study; one or more sites; appendicular skeleton) as a more appropriate reference code. This code has a work value of .22 and an intra-service time of 5 minutes which is quite similar to 76514. It has a longer post service time and for that reason the work RVU chosen for the new code is lower than 76076. The proposed value also compares most favorably with 99211(0.17 WRVU) which has no pre-service time, an intra-service time of 5 minutes and 2 minutes of post service time.

A question had been raised at the CPT meeting on the nature of the physician work for this code. It is just a number like a blood pressure reading? There is work in performing the test itself and interpreting its results. The patient described in the vignette would typically be subjected to diagnostic testing for damage from the elevated intraocular pressure. These tests would include quantitative visual fields, gonioscopy and optic nerve imaging studies. If this patient is found to have a thicker cornea than normal on pachymetry, a nomogram can be used to determine the "true " intraocular pressure which will be lower than applanation tonometry. This normalized

pressure is recorded and the imports of the findings are related to the patient. Most of these patients will no longer be subjected to periodic diagnostic testing and some who were on drops can be discontinued.

The applanation of the central cornea could be done by a technician but typically will be performed by a physician. If the readings are taken by the technician rather than the physician, the physician still must establish the validity and import of the findings. If the corneal readings are thin, does the increased "true" pressure constitute a risk to the patient? If the difference in the applanation and corrected pressure using pachymetry significant enough to change the observation or management of the patient?

---

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

Corneal pachymetry is almost always performed on a patient on the same day as an EM service.

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

The level of EM code selected is dependent on the nature of the presenting problem and the physician work involved.

---

**FREQUENCY INFORMATION**

How was this service previously reported? 0025T(new technology code) (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty ophthalmology  Commonly  Sometimes  Rarely

Specialty \_\_\_\_\_  Commonly  Sometimes  Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAO Frequency Appx. 1.2 million in first few years

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty Ophthalmology Frequency: Once a lifetime to patients with the diagnoses of glaucoma, glaucoma suspect, ocular hypertension. It would also be provided once a lifetime to populations at risk for developing glaucoma: African Americans age 50 and older; Medicare beneficiaries with a family history of glaucoma and diabetics.

Specialty AAO Frequency approximately 800,000 in first few years

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

		76514	
	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Corneal Pachymetry Echography	
LOCATION		In Office	Office
<b>GLOBAL PERIOD</b>	XXX		
<b>TOTAL CLINICAL LABOR TIME</b>	1121	5.0	0.0
<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>	1121	1.0	0.0
<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>	1121	4.0	0.0
<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>	1121	0.0	0.0
<b>PRE-SERVICE</b>			
LOCATION		In Office	Out Office
<b>Start: Following visit when decision for surgery or procedure made</b>			
Complete pre-service diagnostic & referral forms		0	0
Coordinate pre-surgery services		0	0
Schedule space and equipment in facility		0	0
Provide pre-service education/obtain consent		1	0
Follow-up phone calls & prescriptions		0	0
Other Clinical Activity (please specify)			
<b>End:When patient enters office/facility for surgery/procedure</b>			
<b>SERVICE PERIOD</b>			
<b>Start: When patient enters office/facility for surgery/procedure</b>			
<b>Pre-service services</b>			
Review charts		0	
Greet patient and provide gowning		0	
Obtain vital signs		0	
Provide pre-service education/obtain consent		0	
Prepare room, equipment, supplies		2	
Prepare and position patient/ monitor patient/ set up IV		0	
Sedate/apply anesthesia			
<b>Intra-service</b>			
Assist physician in performing procedure		2	
<b>Post-Service</b>			
Monitor pt. following service/check tubes, monitors, drains		0	
Clean room/equipment by physician staff		0	
Clean Scope		0	
Complete diagnostic forms, lab & X-ray requisitions		0	

Review/read X-ray, lab, and pathology reports		0	
Check dressings & wound/ home care instructions			
/coordinate office visits /prescriptions		0	
Discharge day management 99238 --12 minutes			
99239 --15 minutes		0	
Other Clinical Activity (please specify)		0	
<b>End: Patient leaves office</b>			
<b>POST-SERVICE Period</b>			
<b>Start: Patient leaves office/facility</b>			
<b>Clean surgical medium tray</b>			
Conduct phone calls/call in prescriptions		0	
<i>Office visits: Greet patient,escort to room; provide gowning; interval history &amp; vital signs and chart; assemble previous test reports/results;assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care</i>			
<i>List Number and Level of Office Visits</i>			
99211 16 minutes	16	0	
99212 27 minutes	27	0	
99213 36 minutes	36	0	
99214 53 minutes	53	0	
99215 63 minutes	63	0	
Other			
<i>Total Office Visit Time</i>		0	0
Other Activity (please specify)			
<b>End: with last office visit before end of global period</b>			
<b>MEDICAL SUPPLIES</b>			
<b>Equipment</b>			
Ultrasonic pachymeter DGH 550 Pachette 2/ \$3945.00		1	

**Sample Report/Note:**

The corneal thicknesses were measured with contact ultrasound using the Chiron Cornea-Gage. The right was 540 microns and the left was 615 microns. IOP measures of the left eye measured with applanation will be artificially increased.



AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Multiple Day Nuclear Medicine Whole Body-Spect Imaging**

***Work Relative Value Recommendations***

Two existing codes were modified and one new code was created to account for the additional physician work and practice expenses when multiple day studies are required to complete nuclear medicine whole body or SPECT tumor imaging studies. Imaging for specific tumors with recently introduced radiopharmaceuticals, increasingly require multiple day studies. In addition, whole body imaging for pretreatment planning prior to radiopharmaceutical therapy must be performed on two or more days.

The RUC and the specialty society recommended that the existing codes have no change in their current physician work values. These two codes were merely modified within CPT to distinguish between imaging during one day and for multiple days. The RUC reviewed codes 78306 *Bone and/or joint imaging; whole body* (Work RVU = 0.86) and 78806 *Radiopharmaceutical localization of inflammatory process; whole body* (Work RVU = 0.86) in relation to revised code 78802 *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area*. In addition, the RUC reviewed the survey results of 78802 and agreed with the specialty society that the current relative value of 0.86 was still appropriate. **The RUC agreed with the rank order between the family of codes and recommends no change in the work relative values for CPT codes 78800 *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area* (Work RVU = 0.66) and 78802 *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, single day imaging* (Work RVU = 0.86)**

New code 78804 *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging* was reviewed by the RUC for its rank order as well as its survey results. The survey results indicated a median RVU of 1.53, however the specialty believed that in order to maintain accurate rank order, this new code should be valued closer to the survey's 25<sup>th</sup> percentile results. In relation to the specialty's key reference service 78806, as well as 78800 and 78802, the RUC accepted the specialty society's recommendations. **The RUC recommends a work relative value of 1.07 for CPT code 78804.**

***Practice Expense Recommendations***

The RUC reviewed the in office practice expense recommendations for CPT codes 78802 and 78804. The specialty explained that the direct practice expense inputs for these codes were crosswalked from code 78306 *Radiopharmaceutical localization of inflammatory process; whole body*, and should be placed into the non-physician work pool. These services were explained by the presenters as typically performed in the non-facility setting and there would not be facility practice expense inputs for these codes. The RUC believed that the non-facility inputs were typical for the services provided, and accepted the data without modification.

CPT Code (•New)	Track ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
▲ 78800		Radiopharmaceutical localization of tumor <u>or distribution of radiopharmaceutical agent(s); limited area</u>  (For specific organ, see appropriate heading)	XXX	0.66  (no change)
▲ 78802	II1	whole body, <u>single day imaging</u>	XXX	0.86  (no change)
● 78804	II2	whole body, requiring two or more days imaging	XXX	1.07

CPT Code: 78802

Tracking No: III Global: XXX

Recommended RVW: 0.86

**Descriptor: Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, single day imaging**

---

### **Clinical Description of Service**

#### **Vignette Used in Survey (typical patient):**

A 69-year man, who is one year post therapy for Hodgkin's lymphoma and now has recurrent fever and weight loss, is referred for restaging. Imaging is concluded in a single day.

**Percentage of Survey Respondents who found Vignette to be Typical: 100%**

#### **Description of Pre-Service Work:**

- Patient history reviewed and the order for the procedure confirmed
- Review prior applicable imaging studies
- Order radiopharmaceutical and dosage to be administered
- Equipment quality control review and oversight

#### **Description of Intra-Service Work**

- Regulatory documentation, review and oversight for ordering and administering radioactive materials
- Preliminary review of images during acquisition, to assure that all needed images are acquired free of motion and artifacts, including determination if image filter is necessary
- Interpret imaging data
- Comparison of previous pertinent imaging studies
- Dictate report for medical record

#### **Description of Post-Service Work**

- Review and sign report
- Communicate finding to referring physician and patient as appropriate
- Regulatory documentation, review and oversight for waste and disposal of radioactive materials

**SURVEY DATA**

<b>Presenter(s):</b>	Bibb Allen, Jr., M.D. (ACR), Michael A. Wilson, M. D. (SNM), and Kenneth A. McKusick, M.D. (SNM)					
<b>Specialty(s):</b>	American College of Radiology, Society of Nuclear Medicine					
<b>CPT Code:</b>	78802					
<b>Sample Size:</b>	167	<b>Resp n:</b>	19	<b>Resp %:</b>	11%	
<b>Sample Type:</b> Random						
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		0.86	0.90	1.00	1.25	1.55
<b>Pre-Service Time:</b>				12.50		
<b>Pre-Service Evaluation Time:</b>						
<b>Pre-Service Positioning Time:</b>						
<b>Pre-Service Scrub, Dress, Wait Time:</b>						
<b>Intra-Service Time:</b>		5.00	11.25	17.50	27.50	90.00
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	10.00					
<b>Critical Care time/visit(s):</b>						
<b>Other Hospital time/visit(s):</b>						
<b>Discharge Day Mgmt:</b>						
<b>Office time/visit(s):</b>						

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

CPT	Descriptor	2003 RVW	Glob
78806	Radiopharmaceutical localization of inflammatory process; whole body	0.86	XXX

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE:**

	Svy CPT	Ref CPT
<b>TIME ESTIMATES (MEDIAN)</b>		
Pre-service	12.50	
Intra-service	17.50	23 (Harvard)
Same Day Immediate Post-service	10.00	
Critical care		
Other hospital visit		
Discharge day management		
Office visit		
<b>TOTAL TIME</b>	40.00	23 (Harvard)
<b>INTENSITY/COMPLEXITY MEASURES (mean)</b>		
Survey Count		6
<b>TIME SEGMENTS</b>		
Pre-service	2.33	2.17
Intra-service	3.83	3.17
Post-service	2.33	2.33
<b>MENTAL EFFORT AND JUDGMENT</b>		
The number of possible diagnosis and/or the number of management options that must be considered	3.67	2.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.67
Urgency of medical decision making	3.67	3.67
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>		
Technical skill required	3.50	2.83
Physical effort required	2.00	2.00
<b>PSYCHOLOGICAL STRESS</b>		
The risk of significant complications, morbidity and/or mortality	3.50	3.33
Outcome depends on the skill and judgment of physician	3.83	3.67
Estimated risk of malpractice suit with poor outcome	3.17	3.17

**ADDITIONAL RATIONALE**

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

A consensus panel consisting of physicians from the American College of Radiology and Society of Nuclear Medicine was formed. The consensus panel reviewed the survey data and recommends a RVW of 0.86.

**Services Reported with Multiple CPT Codes**

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

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

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

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

**FREQUENCY INFORMATION**

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

78802: Radiopharmaceutical localization of tumor; whole body

**How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty Radiology X Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_  
 Specialty \_\_\_\_\_ \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty Radiology Frequency 315,000  
 Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty Radiology Frequency 15,000  
 Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

CPT Code: 78804

Tracking No: II2

Global: XXX

Recommended RVW: 1.07

**Descriptor:** Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging

---

### Clinical Description of Service

#### Vignette Used in Survey (typical patient):

A 62-year-old man with long standing histologically confirmed B-cell Non-Hodgkins Lymphoma has relapsed with fever and pain, and has tumor recurrence confirmed by chest x-ray and CT studies. He has failed other prior radiation and chemotherapy treatment. Treatment with Y90 Zevalin is contemplated, and he is referred for a radiopharmaceutical distribution imaging required prior to Zevalin treatment.

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

#### Description of Pre-Service Work:

- Patient history reviewed and the order for the procedure confirmed
- Review prior applicable imaging studies
- Order radiopharmaceutical and dosage to be administered
- Equipment quality control review and oversight
- Provide instruction to the patient regarding the infusion, including review of potential reactions, and obtain signed consent

#### Description of Intra-Service Work

- Regulatory documentation, review and oversight for ordering and administering radioactive materials
- Personally supervise slow infusion of the indium-111 labeled antibody, paying particular attention for potential reaction
- Preliminary review, at the time of acquisition, 24 hour images and 48 hour images, to assure that all needed images are acquired free of motion and artifacts, including determination if image filter is necessary
- Interpret two to three sets of image data
- Provide qualitative assessment of biodistribution and determination of feasibility of treatment with monoclonal antibody
- Comparison of previous pertinent imaging studies
- Dictate report for medical record

#### Description of Post-Service Work

- Review and sign report
- Communicate finding to referring physician and patient as appropriate
- Regulatory documentation, review and oversight for waste and disposal of radioactive materials

**SURVEY DATA**

<b>Presenter(s):</b>	Bibb Allen, Jr., M.D. (ACR), Michael A. Wilson, M. D. (SNM), and Kenneth A. McKusick, M.D. (SNM)					
<b>Specialty(s):</b>	American College of Radiology, Society of Nuclear Medicine					
<b>CPT Code:</b>	78804					
<b>Sample Size:</b>	167	<b>Resp n:</b>	19	<b>Resp %:</b>	11%	
<b>Sample Type:</b> Random						
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		0.86	1.00	1.53	1.96	3.00
<b>Pre-Service Time</b>				30.00		
<b>Pre-Service Evaluation Time:</b>						
<b>Pre-Service Positioning Time:</b>						
<b>Pre-Service Scrub, Dress, Wait Time:</b>						
<b>Intra-Service Time:</b>		5.00	17.50	20.00	30.00	120.00
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	20.00					
<b>Critical Care time/visit(s):</b>						
<b>Other Hospital time/visit(s):</b>						
<b>Discharge Day Mgmt:</b>						
<b>Office time/visit(s):</b>						

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

CPT	Descriptor	2003 RVW	Glob
78806	Radiopharmaceutical localization of inflammatory process; whole body	0.86	XXX

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE:**

	Svy CPT	Ref CPT
<b>TIME ESTIMATES (MEDIAN)</b>		
Pre-service	30.00	
Intra-service	20.00	23 (Harvard)
Same Day Immediate Post-service	20.00	
Critical care		
Other hospital visit		
Discharge day management		
Office visit		
<i>TOTAL TIME</i>	70.00	23 (Harvard)
<b>INTENSITY/COMPLEXITY MEASURES (mean)</b>		
Survey Count		6
<b>TIME SEGMENTS</b>		
Pre-service	3.67	1.83
Intra-service	3.67	3.17
Post-service	2.83	2.00
<b>MENTAL EFFORT AND JUDGMENT</b>		
The number of possible diagnosis and/or the number of management options that must be considered	2.67	2.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.50
Urgency of medical decision making	3.50	3.67
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>		
Technical skill required	3.17	2.67
Physical effort required	2.50	2.00
<b>PSYCHOLOGICAL STRESS</b>		
The risk of significant complications, morbidity and/or mortality	3.67	3.00
Outcome depends on the skill and judgment of physician	3.83	3.83
Estimated risk of malpractice suit with poor outcome	3.83	3.17

**ADDITIONAL RATIONALE**

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

A consensus panel consisting of physicians from the American College of Radiology (ACR) and Society of Nuclear Medicine (SNM) was formed. They reviewed the survey data. While the time and intensity in the survey data support the median value of 1.53 RVW, in order to preserve rank order with CPT code 78802, the consensus panel recommends a value of 1.07 RVW as the work value for CPT code 78804.

The new work value of 78804 should be considered 'new work' and not budget neutral with 78802. Prior to the introduction of Zevalin as a radiolabeled monoclonal antibody therapy for malignant neoplasm, multiday imaging for tumor localization was atypical accounting for only 10% of the cases reported using 78802. With the advent of Zevalin, biodistribution profile is mandated prior to administration of the therapy dose, and imaging is necessarily obtained on two or more days. CPT code 78802 is valued on the basis of the typical tumor imaging case (90%) where imaging occurs on the same day as the injection. Additionally, the creation of G0273 to report the biodistribution study for Zevalin also supports the supposition that 78804 is new physician work.



**AMA/Specialty Society Update Process  
RUC Summary of Recommendation  
XXX Global Period  
In Office Direct Inputs**

Sample Size: 26 Response Rate: (%): 69.2% Global Period: XXX

Tracking Number: III Reference Code 1 78306 Reference Code 2           

Geographic Practice Setting %: Rural 0% Suburban 100% Urban 0%

Type of Practice %: 0% Solo Practice  
50% Single Specialty Group  
50% Multispecialty Group  
0% Medical School Faculty Practice Plan

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

Practice Expense was derived from data collected in previous surveys and the building block methodology used for nuclear medicine codes previously approved by the PEAC.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Review X-ray, scan, lab, and past tests to confirm appropriateness of procedure with physician; confirm technique to be used and any special views required, obtain physician written directive, determine radiopharmaceutical dose, and order the radiopharmaceutical from the commercial central pharmacy.
- QC Planar Equipment to be used in scan
- Prepare radiopharmaceutical delivered by central pharmacy with NRC and DOT required check-in of RP, survey package, wipe test of package and recording all. Ready dose for potential infusions/injection with in-house labels and records, and later resurvey and arrange disposal of syringe

Intra-Service Clinical Labor Activities:

- Obtain RP dose from radiopharmaceutical receiving and storage area, reassay and record dose data, ensure dose would be appropriate for the patient based on the written directive (correct test and patient weight)
- Take patient to injection area, inject radiopharmaceutical, review radiation risks to those at home, escort back to waiting area, send home with instructions on when to return for scan.
- Specific room clean up of injection area with defacement of labels, and required NRC survey and monitoring tasks
- Take patient to scan room; acquire images and review each set of raw data for completeness, include time between acquisition of images; preliminary review of images by physician and approval to discharge

**CPT Code: 78802**

**Specialty Society('s) SNM/ACR**

- Education/Instruction/Counseling as patient is taken back to waiting area after scanning session with emphasis on radiation risk to those at home; discharge patient
- Clean scan rooms/equipment after each scanning session

Post-Service Clinical Labor Activities:

- Post processing of raw data into final format, development of hard copy, archiving
- Regulatory compliance – NRC required wipe tests and surveys of area used, and documentation

CPT Code: 78802

Specialty Society('s) SNM/ACR

Total Staff Time In Office: **148 minutes**

Visits in Global Period: **2 Visits - (Injection and Imaging session)**

HCFA's Staff Type Code*	Clinical Labor	Total Pre-Service Time	Total Service Period (Day of service)	Total Post-Service Time After Day of Service)	Total Pre-Service, Service, and Post Service Time	Cost Estim and Source applicable)
1023	Nuclear Medicine Technologist (Nuc Med Tech)	25	100	23	148	

\* From HCFA's Labor, Medical Supply, and Equipment List for year 2002. If not listed, provide full description, estimated cost, and cost source.

CMS Medical Supply Code*	Medical Supplies	Injection Visit	Imaging Visit	Units	Cost Estimate and Source (if applicable)
11302	Gloves, non-sterile	1	0	pair	
11102	Chux	1	0	each	
xxxxx	QC Wipes	5	0	each	\$0.13*
53003	Alcohol swabs	1	0	each	
91106	Angiocath with heplock	1	0	each	
91111	Stop cock, 3-way	1	0	each	
31502	Band aid	1	0	each	
11102	Chux	1	0	each	
31506	Gauze, 2x2	1	0	each	
11302	Gloves, non-sterile	1	0	each	
53062	Saline, 30 ml	1	0	each	
53090	Heparin flush	1	0	each	
91415	Syringe, 3 cc	0	0	each	
91407	Syringe, 10 cc	1	0	each	
91402	Needles, 19-25 g	1	0	each	
11139	Paper, table	0	7 feet	each	
11112	Pillow case – disposable	0	1	each	
11106	Drape sheet	0	1	each	
73404	Film 8x10	0	1	each	
73423	Film developer/cost/exposure	0	1	each	
xxxxxx	Film Jacket (10x12) for scan	0	1	each	\$0.28*

\* From HCFA's Labor, Medical Supply, and Equipment List for year 2002. If not listed, provide full description, estimated cost, and cost source.

CMS Equipment Code*	Medical Equipment	Injection Visit Time	Imaging Time	Unit	Cost Estimate and Source (if applicable)
<b>Radiopharmaceutical Receiving</b>					
E51064	Dose Calibrator	48 min	0	1	
xxxxx	Dedicated pharmacy computer and printer	48 min	0	1	\$20,295*
xxxxx	Calibration source vial set & check sleeves	48 min	0	1	\$1,505*
xxxxx	Autogama counter	48 min	0	1	\$26,637*
E53004	Survey meter	48 min	0	1	
xxxxx	L-Block Table Shield	48 min	0	1	\$725*
xxxxx	Syringe Shields & Lead Holders (6)	48 min	0	6	\$1,310*
xxxxx	Lead-lined radioactive waste & lead-lined Sharps box	48 min	0	1	\$935*
xxxxx	Lead Shielding	48 min	0		\$2,150*
xxxxx	Y-90 Syringe Shields (2)	0	0	0	\$135*
xxxxx	Y-90 Dose Injector, Manual	0	0	0	\$595*
<b>Injection Room</b>					
xxxxx	Phlebotomy-Injection Chair	48 min	0	1	* 519
xxxxx	Bed	0	0	0	\$4450*
E91001	IV Infusion Pump	0	0	0	
<b>Imaging Area</b>					
E53020	Single/dual head camera, imaging table, computer & software	0	1	1	
E53004	Co-57 Flood Source	0	1	1	
E51002	Film Processor	0	1	1	
E51001	View Boxes	0	1	1	
xxxxx	Physician Analysis & View Station	0	1	1	* \$35,000
xxxxx	Medium Energy Collimator **	0	1	1	* \$14,000

\* Catalog information and pricing provided to CMS following the January 2002 PEAC Meeting

\*\* Siemen's Catalog #05232868

**Type of Service: Evaluation/Management Services or Diagnostic Tests  
XXX Global Period**

**SITE OF SERVICE: In-Office  
Clinical Services**

	Injection Visit	Imag ing Visit	Total Minutes	
<b>Pre-Service Period</b>				
<i>Start: When appointment for service is made</i>				
Review X-ray, scan, lab, and past tests to confirm appropriateness of procedure with physician; confirm technique to be used and any special views required, obtain physician written directive, determine radiopharmaceutical dose, and order the radiopharmaceutical from the central commercial pharmacy.	8	0	8	Nuc Med Tech
<i>Other Clinical Activity (please specify)</i>				
QC Planar Equipment to be used in scan	0	4	4	Nuc Med Tech
Prepare radiopharmaceutical delivered by central pharmacy with NRC and DOT required check-in of RP, survey package, wipe test of package and recording all. Ready dose for potential injection with in-house labels and records, and later resurvey and arrange disposal of syringe.	13	0	13	Nuc Med Tech
<i>End: Patient arrival at office for service</i>				
<b>Total Pre-Service Time</b>	<b>21</b>	<b>4</b>	<b>25</b>	
<b>Day of Injection</b>				
<i>Start: Patient arrival at office for service</i>				
Prepare injection room, equipment and supplies	2	0	2	Nuc Med Tech
Obtain RP dose from radiopharmaceutical receiving and storage area, reassay and record dose data, ensure dose would be appropriate for the patient based on the written directive (correct test and patient weight).	7	0	7	Nuc Med Tech
Greet patient/provide gowning if appropriate and take patient to injection area, inject radiopharmaceutical, review radiation risks, and escort back to waiting area; arrange for later imaging session, provide instruction on radiopharmaceutical risk.	10	0	10	Nuc Med Tech
Specific room clean up of injection area with defacement of labels, and required NRC survey and monitoring tasks.	4	0	4	Nuc Med Tech
<b>Day of Imaging</b>				
Greet patient/provide gowning if appropriate, and take to injection or imaging area.	0	3	3	Nuc Med Tech

Obtain vital signs	0	0	0	
Prepare room, equipment, supplies, and set up protocol and change collimator on imaging device for each image session.	0	2	2	Nuc Med Tech
Prep and position patient in scanner while explaining scan for imaging session.	0	3	3	Nuc Med Tech
Acquire image(s) and review each set of raw data for completeness, include time between acquisition of images.	0	61	61	Nuc Med Tech
Coordinate home or outpatient care	0	0	0	
Obtain preliminary review of images by physician; approval to discharge	0	2	2	Nuc Med Tech
Clean room/equipment after each scan session	0	3	3	Nuc Med Tech
Education/Instruction/Counseling as patient is taken back to waiting area after scanning session with emphasis on radiation risk to those at home; Discharge	0	3	3	Nuc Med Tech
<b>Total Intra-service</b>	<b>23</b>	<b>77</b>	<b>100</b>	

**Post-Service Period**

Start: Patient leaves office

## Other Activity (please specify)

Post processing of raw data into final format, development of hard copy, archiving.	0	15	15	Nuc Med Tech
Regulatory compliance-NRC required wipe tests and surveys of areas used, and documentation	4	4	8	Nuc Med Tech

End: Last visit before end of global period

<b>Total Post-Service Time</b>	<b>4</b>	<b>19</b>	<b>23</b>	
--------------------------------	----------	-----------	-----------	--

Revised April 14, 2002 (BU)

PEAC Codes 78802				
AMA/Specialty Society RUC Recommendation		CPT 78306	CPT 78802	
(*) Modified and/or Specific to Nuclear Medicine	HCFA STAFF TYPE, MEDICAL SUPPLY OR EQUIPMENT CODE	78306 Bone Whole Body Planar Single Imaging Session	78802 Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); WB, single day imaging	
LOCATION		In Office	In Office	
GLOBAL PERIOD			148 minutes	
TOTAL CLINICAL LABOR TIME		121	48 min	100 min
PRE-SERVICE			Injection	Imaging
Start: Following visit when decision for surgery or procedure is made.				
(*) Review X-ray, scan, lab, and past tests to confirm appropriateness of procedure with physician; confirm technique to be used and any special views required, obtain physician written directive, determine radiopharmaceutical dose, and order the radiopharmaceutical from the commercial central pharmacy	NMT	8	8	0
(*) Other Clinical Activity (please specify)				
QC Planar Equipment to be used in scan	NMT	4	0	4
QC SPECT Equipment to be used in scan	NMT	0	0	0
Prepare radiopharmaceutical delivered by central pharmacy with NRC and DOT required check-in of RP, survey package, wipe test of package and recording all Ready dose for potential infusion/injection with in-house labels and records, and later resurvey and arrange disposal of syringe	NMT	13	13	0
Coordinate the administration of the 2nd antibody (radioactive) infusion-injection, which follows 2-4 hours after 1st "cold" antibody infusion/injection requiring modification of schedule and personnel	NMT	0	0	0
Coordinate the administration of the therapy (radioactive) antibody infusion which follows within 4 hours of the IV infusion of "cold" Rituximab (Oncologist), requiring modification of schedule and personnel	NMT		0	0
<b>Total Pre-Service Time</b>	<b>NMT</b>	<b>25</b>	<b>21</b>	<b>4</b>
End: Patient enters office for surgery/procedure				
SERVICE PERIOD				
Start: When patient enters office for surgery/procedure				
Review charts				
(*) Greet patient, provide gowning if appropriate, and take to imaging area for imaging session(s)	NMT	3	0	3
Obtain vital signs	NMT	0	0	0
(*) Prepare room, equipment, supplies, and set up protocol and change collimator on imaging device for each imaging session	NMT	2	0	2
(*) Prep and position patient in scanner while explaining scan for imaging session	NMT	3	0	3
(*) Prepare infusion/injection room, equipment, and supplies	NMT	0	2	0
<b>Intra-service</b>				
Assist physician during drug therapy infusion to include preparation and assistance during possible medical emergency/antibody mucous reaction (oxygen, crash cart)	NMT		0	0
(*) Education/Instruction/Counseling as patient is taken back to waiting area after each scanning session with emphasis on radiation risk to those at home	NMT	3	0	3
(*) Coordinate home or outpatient care	NMT	0	0	0
(*) Clean scan rooms/equipment after each scanning session	NMT	3	0	3
(*) Specific room clean up of injection area with defacement of labels, and required NRC survey and monitoring tasks	NMT	4	4	0

PEAC Codes 78802				
AMA/Specialty Society RUC Recommendation		CPT 78306	CPT 78802	
(*) Modified and/or Specific to Nuclear Medicine	HCFA STAFF TYPE, MEDICAL SUPPLY OR EQUIPMENT CODE	78306 Bone Whole Body Planar Single Imaging Session	78802 Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); WB, single day imaging	
<b>Other Clinical Activity (please specify)</b>				
(*) Obtain RP dose from radiopharmaceutical receiving and storage area, reassay and record dose data, ensure dose would be appropriate for the patient based on the written directive (correct test and patient weight)	NMT	7	7	0
(*) Take patient to injection area, set up IV, infuse/inject radiopharmaceutical, review radiation risks, escort back to waiting area	NMT	10	10	0
(*) Acquire images and review each set of raw data for completeness, include time between acquisition of images (1 min)	NMT	42	0	61
Approval of Images - obtain approval as to quality of study and ability to discharge patient		0	0	2
<b>Service Period Total</b>	<b>NMT</b>	<b>77</b>	<b>23</b>	<b>77</b>
<b>End: Patient leaves office</b>				
<b>Post-Service Period</b>				
<b>Start: Patient leaves office</b>				
<b>Other Activity (please specify)</b>				
(*) Post processing of raw data into final format, development of hard copy, archiving	NMT	15	0	15
(*) Regulatory compliance -NRC required wipe tests and surveys of areas used, and documentation	NMT	4	4	4
<b>Post Service Total</b>	<b>NMT</b>	<b>19</b>	<b>4</b>	<b>19</b>
<b>End: With last office visit before end of global period</b>				
<b>MEDICAL SUPPLIES</b>				
<b>RADIOPHARMACEUTICAL - STORAGE AND RECEIVING AREA</b>				
11302 Gloves, non-sterile	11302	1	1	0
11102 Chux	11102	1	1	0
XXXXX QC Wipes	* \$0.13 ea	5	5	0
<b>INJECTION AREA</b>				
Alcohol Swabs	53003	1	1	0
Angiocath with heplock	91106	1	1	0
Stop cock, 3 way	91111	1	1	0
Band aid	31502	1	1	0
Chux	11102	1	2	0
Gauze, 2x2	31506	1	1	0
Gloves, non-sterile	11302	1	1	0
Saline 30 ml	53062	1	1	0
Hepann flush	53090	1	1	0
Synnge, 3cc	91415	0	0	0
Synnge, 10cc	91407	1	1	0
Needles, 19-25 g	91402	1	1	0
<b>IMAGING AREA</b>				
Paper, table	11139	7 Feet	0	7 Feet
Pillow case - disposable	11112	1	0	1
Drape sheet	11106	1	0	1
Film 8x10	73404	1	0	1
Film developer/ cost per exposure	73423	1	0	1
Film Jacket (10x12 inch) for this scan	* \$0.28 ea	1	0	1
* From HCFA's Labor, Medical Supply, and NM Equipment List for year 2000 If not listed, provide full description, estimated cost, and cost source				
<b>Equipment</b>				
<b>Radiopharmaceutical Receiving Area</b>				
(This is a fixed room for future codes)				
Dose Calibrator	E51064	121 min	48 min	100 min
Dedicated pharmacy computer and printer	* \$20,295	121 min	48 min	100 min
Calibration Source Vial Set & Check Sleeves	\$1,505	121 min	48 min	100 min
Autogamma Counter	** \$26,637	121 min	48 min	100 min
Survey meter	E53004	121 min	48 min	100 min
L-Block Table Shield	* \$725	121 min	48 min	100 min
Synnge Shields & Lead Pig Holders (6)	* \$1,310	121 min	48 min	100 min

PEAC Codes 78802				
AMA/Specialty Society RUC Recommendation			CPT 78306	CPT 78802
(*) Modified and/or Specific to Nuclear Medicine		HCFA STAFF TYPE, MEDICAL SUPPLY OR EQUIPMENT CODE	78306 Bone Whole Body Planar Single Imaging Session	78802 Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); WB, single day imaging
Lead-lined radioactive waste and lead lined Sharps box		* \$935	121 min	48 min 100 min
Lead shielding		* \$2,150	121 min	48 min 100 min
Y-90 Syringe Shields (2)		\$0	0	0 0
<b>Injection Room</b>				
(This is a fixed room for future codes)				
Phlebotomy-Injection Chair		* \$519	0	48 min 0
Bed		E11015	121 min	0 0
IV Infusion Pump		E91001	0	0 0
<b>Imaging Area:</b>				
(This is a fixed room for future codes)				
Single/dual head camera, Imaging Table, computer and software		E53020	96 min	0 100 min
Co-57 flood source		E53004	96 min	0 100 min
Film processor		E51002	96 min	0 100 min
View Boxes		E51001	96 min	0 100 min
Physician Analysis & Viewing Station		* \$35,000	96 min	0 100 min
Medium Energy Collimator (Siemens catalog #05232868)		* \$14,200		0 100 min
Information provided to CMS January 2002 PEAC Meeting				
* 61 minutes (Survey: Single head WB, 30 min per view (2 views), 1 min between views)				

**AMA/Specialty Society Update Process**  
**RUC Summary of Recommendation**  
**XXX Global Period**  
**In Office Direct Inputs**

Sample Size: 26    Response Rate: (%): 69.2%    Global Period: XXX

Tracking Number: II2    Reference Code 1 78306    Reference Code 2       

Geographic Practice Setting %: Rural 0%    Suburban 100%    Urban 0%

Type of Practice %:    0% Solo Practice  
                              50% Single Specialty Group  
                              50% Multispecialty Group  
                              0% Medical School Faculty Practice Plan

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

Practice Expense was derived from data collected in previous surveys and the building block methodology used for nuclear medicine codes previously approved by the PEAC.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Review X-ray, scan, lab, and past tests to confirm appropriateness of procedure with physician; confirm technique to be used and any special views required, obtain physician written directive, determine radiopharmaceutical dose, and order the radiopharmaceutical from the commercial central pharmacy.
- QC Planar Equipment to be used in scan
- Prepare radiopharmaceutical delivered by central pharmacy with NRC and DOT required check-in of RP, survey package, wipe test of package and recording all. Ready dose for potential infusions/injection with in-house labels and records, and later resurvey and arrange disposal of syringe
- Coordinate the administration of the 2<sup>nd</sup> antibody (radioactive) infusion-injection, which follows 2-4 hours after 1<sup>st</sup> "cold" antibody infusion/injection requiring modification of schedule and personnel.

Intra-Service Clinical Labor Activities:

- Obtain RP dose from radiopharmaceutical receiving and storage area, reassay and record dose data, ensure dose would be appropriate for the patient based on the written directive (correct test and patient weight)
- Take patient to injection/infusion area, administer radiopharmaceutical, review radiation risk to those at home, escort back to waiting area, send home with instructions on when to return for scan.
- Assist physician during infusion to include preparation and assistance during possible medical emergency/antibody murine reaction (oxygen, crash cart)

**CPT Code:78804**  
**Specialty Society('s)SNM/ACR**

- Specific room clean up of injection area with defacement of labels, and required NRC survey and monitoring tasks
- Take patient to scan room; acquire images and review each set of raw data for completeness, include time between acquisition of images; preliminary review of images by physician and approval of discharge
- Education/Instruction/Counseling as patient is taken back to waiting area after each scanning/therapy session with emphasis on radiation risk to those at home; discharge patient when appropriate
- Clean scan rooms/equipment after each scanning session

**Post-Service Clinical Labor Activities:**

- Regulatory compliance – NRC required wipe tests and surveys of area used, and documentation

**CPT Code:78804**  
**Specialty Society('s)SNM/ACR**

Total Staff Time In Office: **288 minutes**      Visits in Global Period: **3 Visits - (Injection and Two or more Imaging)**

HCFA's Staff Type Code*	Clinical Labor	Total Pre-Service Time	Total Service Period (Day of service)	Total Post-Service Time After Day of Service)	Total Pre-Service, Service, and Post Service Time	Cost Estim. and Source applicable)
1023	Nuclear Medicine Technologist (Nuc Med Tech)	<b>44</b>	<b>202</b>	<b>42</b>	<b>288</b>	

\* From HCFA's Labor, Medical Supply, and Equipment List for year 2002. If not listed, provide full description, estimated cost, and cost source.

CMS Medical Supply Code*	Medical Supplies	Infusion Visit	1 <sup>st</sup> Imaging Visit	2 <sup>nd</sup> Imaging Visit	Units	Cost Estimate and Source applicable)
11302	Gloves, non-sterile	1	0	0	pair	
11102	Chux	1	0	0	each	
xxxxx	QC Wipes	5	0	0	each	\$0.13*
53003	Alcohol swabs	1	0	0	each	
91106	Angiocath with heplock	1	0	0	each	
91111	Stop cock, 3-way	1	0	0	each	
31502	Band aid	1	0	0	each	
11102	Chux	1	0	0	each	
31506	Gauze, 2x2	1	0	0	each	
11302	Gloves, non-sterile	1	0	0	each	
53062	Saline, 30 ml	1	0	0	each	
53090	Heparin flush	1	0	0	each	
91415	Syringe, 3 cc	0	0	0	each	
91407	Syringe, 10 cc	1	0	0	each	
91402	Needles, 19-25 g	1	0	0	each	
11139	Paper, table	0	7 feet	7 feet	each	
11112	Pillow case – disposable	0	1	1	each	
11106	Drape sheet	0	1	1	each	
73404	Film 8x10	0	1	1	each	
73423	Film developer/cost/exposure	0	1	1	each	
xxxxxx	Film Jacket (10x12) for scan	0	1	0	each	\$0.28*

\* From HCFA's Labor, Medical Supply, and Equipment List for year 2002. If not listed, provide full description, estimated cost, and cost source.

**CPT Code:78804**  
**Specialty Society('s)SNM/ACR**

<b>CMS Equipment Code*</b>	<b>Medical Equipment</b>	<b>Infusion Visit</b>	<b>1<sup>st</sup> Imaging Visit</b>	<b>2<sup>nd</sup> Imaging Visit</b>	<b>Unit</b>	<b>Cost Estimate and Source (if applicable)</b>
<b>Radiopharmaceutical Receiving</b>						
E51064	Dose Calibrator	88 min	0	0	1	
xxxxx	Dedicated pharmacy computer and printer	88 min	0	0	1	\$20,295*
xxxxx	Calibration source vial set & check sleeves	88 min	0	0	1	\$1,505*
xxxxx	Autogama counter	88 min	0	0	1	\$26,637*
E53004	Survey meter	88 min	0	0	1	
xxxxx	L-Block Table Shield	88 min	0	0	1	\$725*
xxxxx	Syringe Shields & Lead Holders (6)	88 min	0	0	6	\$1,310*
xxxxx	Lead-lined radioactive waste & lead-lined Sharps box	88 min	0	0	1	\$935*
xxxxx	Lead Shielding	88 min	0	0	1	\$2,150*
xxxxx	Y-90 Syringe Shields (2)	0	0	0	0	
<b>Injection Room</b>						
xxxxx	Phlebotomy-Injection Chair	0	0	0	0	* 519
xxxxx	Electric Bed	88 min	100 min	100 min	3	\$4660*
E91001	IV Infusion Pump	88 min	0	0	1	
<b>Imaging Area</b>						
E53020	Single/dual head camera, imaging table, computer & software	0	1	1	2	
E53004	Co-57 Flood Source	0	1	1	2	
E51002	Film Processor	0	1	1	2	
E51001	View Boxes	0	1	1	2	
xxxxx	Physician Analysis & View Station	0	1	1	2	* \$35,000
xxxxx	Medium Energy Collimator	0	1	1	2	* \$14,000

\* Catalog information and pricing provided to CMS following the January 2002 PEAC Meeting

\*\* Siemen's Catalog #05232868

**Type of Service: Evaluation/Management Services or Diagnostic Tests**  
**XXX Global Period**

**SITE OF SERVICE: In-Office**  
**Clinical Services**

	<b>Infusion Visit</b>	<b>1<sup>st</sup> Imaging Visit</b>	<b>2<sup>nd</sup> Imaging Visit</b>	<b>Total Minutes</b>	
<b>Pre-Service Period</b>					
<i>Start: When appointment for service is made</i>					
Review X-ray, scan, lab, and past tests to confirm appropriateness of procedure with physician; confirm technique to be used and any special views required, obtain physician written directive, determine radiopharmaceutical dose, and order the radiopharmaceutical from the central commercial pharmacy.	8	0	0	8	Nuc Med Tech
<hr/>					
Other Clinical Activity (please specify)					
QC Planar Equipment to be used in scan	0	4	4	8	Nuc Med Tech
Prepare radiopharmaceutical delivered by central pharmacy with NRC and DOT required check-in of RP, survey package, wipe test of package and recording all. Ready dose for potential injection with in-house labels and records, and later resurvey and arrange disposal of syringe.	13	0	0	13	Nuc Med Tech
Coordinate the administration of the 2 <sup>nd</sup> antibody (radioactive) infusion/injection, which follows 2-4 hours after 1 <sup>st</sup> "cold" antibody infusion/injection, requiring modification of schedule and personnel	15	0	0	15	Nuc Med Tech
<b>End: Patient arrival at office for service</b>					
<b>Total Pre-Service Time</b>	<b>36</b>	<b>4</b>	<b>4</b>	<b>44</b>	

**Day of Injection**

**Start: Patient arrival at office for service**

	<b>Injectio n/Infusi on Visit</b>	<b>1<sup>st</sup> Imaging Visit</b>	<b>2<sup>nd</sup> Imaging Visit</b>	<b>Total Minutes</b>	
Obtain RP dose from radiopharmaceutical receiving and storage area, reassay and record dose data, ensure dose would be appropriate for the patient based on the written directive (correct test and patient weight).	7	0	0	7	Nuc Med Tech
Prepare infusion/injection room, equipment and supplies	2	0	0	2	
Greet patient/provide gowning if appropriate, and take to injection area, inject radiopharmaceutical, review radiation risks, and escort back to waiting area; arrange for later imaging sessions, provide instruction on radiopharmaceutical risk.	10	0	0	10	Nuc Med Tech
Assist physician during infusion to include monitoring vital signs, preparation and assistance during possible medical emergency/antibody murine reaction (oxygen/crash cart)	22	0	0	22	Nuc Med Tech
Specific room clean up of injection area with defacement of labels, and required NRC survey and monitoring tasks.	4	0	0	4	Nuc Med Tech
<b>Day of Imaging</b>					
Greet patient/provide gowning if appropriate, and take to imaging area	0	3	3	6	Nuc Med Tech
Obtain vital signs	0	0	0	0	
Prepare room, equipment, supplies, and set up protocol and change collimator on imaging device for each image session.	0	2	2	4	Nuc Med Tech
Prep and position patient in scanner while explaining scan for imaging session.	0	3	3	6	Nuc Med Tech
Acquire image(s) and review each set of raw data for completeness, include time between acquisition of images.	0	61	61	122	Nuc Med Tech
Coordinate home or outpatient care	0	0	0	0	
Obtain preliminary review of images by physician; approval to discharge	0	2	2	4	Nuc Med Tech
Clean room/equipment after each scan session	0	3	3	6	Nuc Med Tech

**CPT Code: 78804**  
**Specialty Society('s)SNM/ACR**

Education/Instruction/Counseling as patient is taken back to waiting area after each scanning/therapy session with emphasis on radiation risk to those at home; Discharge  
*End: Patient leaves office*

	3	3	3	9	Nuc Med Tech
<b>Total Service Time</b>	<b>48</b>	<b>77</b>	<b>77</b>	<b>202</b>	Nuc Med Tech

**Post-Service Period**

Start: Patient leaves office

Other Activity (please specify)

Post processing of raw data into final format, development of hard copy and archiving

	0	15	15	30	Nuc Med Tech
--	---	----	----	----	--------------

Regulatory compliance-NRC required wipe tests and surveys of areas used, and documentation

	4	4	8	16	Nuc Med Tech
--	---	---	---	----	--------------

*End: Last visit before end of global period*

<b>Total Post-Service Time</b>	<b>4</b>	<b>19</b>	<b>19</b>	<b>42</b>	
--------------------------------	----------	-----------	-----------	-----------	--

**April 15, 2003 (BU)**

PEAC Codes 788XX April 15, 2003						
AMA/Specialty Society RUC Recommendation		CPT 78306	CPT 788XX			
(*) Modified and/or Specific to Nuclear Medicine		HCFA STAFF TYPE, MEDICAL SUPPLY OR EQUIPMENT CODE	78306 Bone Whole Body Planar Single Imaging Session	788XX Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); WB, requiring two or more days imaging		
LOCATION		In Office	In Office			
GLOBAL PERIOD			288 minutes			
TOTAL CLINICAL LABOR TIME		121	88 min	100 min	100 min	
PRE-SERVICE			Infusion	Day 1 Imaging	Day 2 or more Imaging	
Start: Following visit when decision for surgery or procedure is made.						
(*) Review X-ray, scan, lab, and past tests to confirm appropriateness of procedure with physician, confirm technique to be used and any special views required, obtain physician written directive, determine radiopharmaceutical dose, and order the radiopharmaceutical from the commercial central pharmacy	NMT	8	8	0	0	
(*) Other Clinical Activity (please specify)						
QC Planar Equipment to be used in scan	NMT	4	0	4	4	
QC SPECT Equipment to be used in scan	NMT	0	0	0	0	
Prepare radiopharmaceutical delivered by central pharmacy with NRC and DOT required check-in of RP, survey package, wipe test of package and recording all Ready dose for potential infusion/injection with in-house labels and records, and later resurvey and arrange disposal of syringe	NMT	13	13	0	0	
Coordinate the administration of the 2nd antibody (radioactive) infusion-injection, which follows 2-4 hours after 1st "cold" antibody infusion/injection requiring modification of schedule and personnel	NMT	0	15	0	0	
Total Pre-Service Time						
	NMT	25	36	4	4	
End: Patient enters office for surgery/procedure						
SERVICE PERIOD						
Start: When patient enters office for surgery/procedure						
Review charts						
(*) Greet patient, provide gowning if appropriate, and take to imaging area for imaging session(s)	NMT	3	0	3	3	
Obtain vital signs	NMT	0	0	0	0	
(*) Prepare room, equipment, supplies, and set up protocol and change collimator on imaging device for each imaging session	NMT	2	0	2	2	
(*) Prep and position patient in scanner while explaining scan for imaging session	NMT	3	0	3	3	
(*) Prepare infusion/injection room, equipment, and supplies	NMT	0	2	0	0	
Assist physician during infusion to include monitoring of vital signs, preparation and assistance during possible medical emergency/antibody murine reaction (oxygen, crash cart)	NMT		22	0	0	
(*) Education/Instruction/Counseling as patient is taken back to waiting area after infusion and each imaging session with emphasis on radiation risk to those at home Discharge after last imaging session	NMT	3	3	3	3	
(*) Coordinate home or outpatient care	NMT	0	0	0	0	
(*) Clean scan rooms/equipment after each scanning session	NMT	3	0	3	3	
(*) Specific room clean up of injection area with defacement of labels, and required NRC survey and monitoring tasks	NMT	4	4	0	0	
Other Clinical Activity (please specify)						
(*) Obtain RP dose from radiopharmaceutical receiving and storage area, reassay and record dose data, ensure dose would be appropriate for the patient based on the written directive (correct test and patient weight)	NMT	7	7	0	0	

PEAC Codes 788XX	April 15, 2003					
AMA/Specialty Society RUC Recommendation			CPT 78306	CPT 788XX		
(*) Modified and/or Specific to Nuclear Medicine		HCFA STAFF TYPE, MEDICAL SUPPLY OR EQUIPMENT CODE	78306 Bone Whole Body Planar Single Imaging Session	788XX Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); WB, requiring two or more days imaging		
(*) Take patient to injection area, set up IV, infuse/inject radiopharmaceutical, review radiation risks, escort back to waiting area, arrange return for simming	NMT	10	10	0	0	0
(*) Acquire images and review each set of raw data for completeness, include time between acquisition of images (1 min)	NMT	42	0	61	61	61
Preliminary approval of images and ability to discharge		0	0	2	2	2
<b>Service Period Total</b>	<b>NMT</b>	<b>77</b>	<b>48</b>	<b>77</b>	<b>77</b>	<b>77</b>
<b>End: Patient leaves office</b>						
<b>Post-Service Period</b>						
<b>Start: Patient leaves office</b>						
Other Activity (please specify)						
(*) Post processing of raw data into final format, development of hard copy and archiving	NMT	15	0	15	15	15
(*) Regulatory compliance –NRC required wipe tests and surveys of areas used, and documentation	NMT	4	4	4	4	4
<b>Post Service Total</b>	<b>NMT</b>	<b>19</b>	<b>4</b>	<b>19</b>	<b>19</b>	<b>19</b>
<b>End: With last office visit before end of global period</b>						
<b>MEDICAL SUPPLIES</b>						
<b>Radiopharmaceutical -Storage &amp; Receiving</b>						
11302 Gloves, non-sterile	11302	1	1	0	0	0
11102 Chux	11102	1	1	0	0	0
XXXXX QC Wipes	* \$0.13 ea	5	5	0	0	0
<b>INJECTION AREA</b>						
Alcohol Swabs	53003	1	1	0	0	0
Angiocath with heplock	91106	1	1	0	0	0
cock, 3 way	91111	1	1	0	0	0
Jaid	31502	1	1	0	0	0
Chux	11102	1	2	0	0	0
Gauze, 2x2	31506	1	1	0	0	0
Gloves, non-sterile	11302	1	1	0	0	0
Saline 30 ml	53062	1	1	0	0	0
Heparin flush	53090	1	1	0	0	0
Syringe, 3cc	91415	0	0	0	0	0
Syringe, 10cc	91407	1	1	0	0	0
Needles, 19-25 g	91402	1	1	0	0	0
<b>IMAGING AREA</b>						
Paper, table	11139	7 Feet	0	7 Feet	7 Feet	7 Feet
Pillow case - disposable	11112	1	0	1	1	1
Drape sheet	11106	1	0	1	1	1
Film 8x10	73404	1	0	1	1	1
Film developer/ cost per exposure	73423	1	0	1	1	1
Film Jacket (10x12 inch) for this scan	* \$0.28 ea	1	0	1	1	1
* From HCFA's Labor, Medical Supply, and NM Equipment List for year 2000 If not listed, provide full description, estimated cost, and cost source						
<b>Equipment</b>						
<b>Radiopharmaceutical Receiving Area</b>						
(This is a fixed room for future codes)						
Dose Calibrator	E51064	121 min	88 min	0	0	0
Dedicated pharmacy computer and printer	* \$20,295	121 min	88 min	0	0	0
Calibration Source Vial Set & Check Sleeves	\$1,505	121 min	88 min	0	0	0
Autogamma Counter	** \$26,637	121 min	88 min	0	0	0
Survey meter	E53004	121 min	88 min	0	0	0
L-Block Table Shield	* \$725	121 min	88 min	0	0	0
Syringe Shields & Lead Pig Holders (6)	* \$1,310	121 min	88 min	0	0	0
Lead-lined radioactive waste and lead lined Sharps box	* \$935	121 min	88 min	0	0	0
Lead shielding	* \$2,150	121 min	88 min	0	0	0
Y-90 Syringe Shields (2)	\$0	0	0	0	0	0
<b>Injection Room</b>						
(This is a fixed room for future codes)						
Phlebotomy-Injection Chair	* \$519	121 min	0	0	0	0
Infusion Pump	* \$4660	0	88 min	100 min	100 min	100 min
	E91001	0	88 min	0	0	0
<b>Imaging Area</b>						
(This is a fixed room for future codes)						
Single/dual head camera, Imaging Table, computer and software	E53020	96 min	0	100 min	100 min	100 min
Co-57 flood source	E53004	96 min	0	100 min	100 min	100 min
Film processor	E51002	96 min	0	100 min	100 min	100 min
View Boxes	E51001	96 min	0	100 min	100 min	100 min

<b>PEAC Codes 788XX</b>		<b>April 15, 2003</b>				
<b>AMA/Specialty Society RUC Recommendation</b>		<b>CPT 78306</b>		<b>CPT 788XX</b>		
<b>(*) Modified and/or Specific to Nuclear Medicine</b>		<b>HCFA STAFF TYPE, MEDICAL SUPPLY OR EQUIPMENT CODE</b>	<b>78306 Bone Whole Body Planar Single Imaging Session</b>	<b>788XX Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); WB, requiring two or more days imaging</b>		
Physician Analysis & Viewing Station		* \$35,000	96 min	0	100 min	100 min
Medium Energy Collimator (Siemens catalog #05232868)		* \$14,200		0	100 min	100 min
Information provided to CMS January 2002 PEAC Meeting						

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Radiolabeled Monoclonal Antibody Infusion**

***Work Recommendation***

Two existing codes were modified and one new code was created to account for a new procedure which describes a systemic treatment by infusion of a radiolabeled monoclonal antibody. The radiopharmaceutical (such as Sr89) is administered as an intravenous injection for which there is no expected immune reaction. The new procedure requires an infusion (not an intravenous injection) over an extended period, of a murine antibody to which there may be an allergic reaction. This procedure is not limited to nonthyroid, nonhematologic tumors, polycythemia and chronic leukemia, and the treatment entails one infusion injection.

The RUC and the specialty society recommended that the existing codes have no change in their current physician work values. These two codes were clarified within CPT to indicate the radiopharmaceutical therapy treatment through intravenous injection. The RUC recommends no change in the work relative values for CPT codes 79100 *Radiopharmaceutical therapy, polycythemia vera, chronic leukemia, each treatment by intravenous injection* (Work RVU = 1.32) and 79400 *Radiopharmaceutical therapy, nonthyroid, nonhematologic by intravenous injection* (Work RVU = 1.96)

New code 79403 *Radiopharmaceutical therapy by, radiolabeled monoclonal antibody by intravenous infusion* was reviewed by the RUC for its rank order and its survey results. The RUC reviewed the specialty society's key reference code 79030 *Radiopharmaceutical ablation of gland for thyroid carcinoma* (Work RVU = 2.10), and the revisions of codes 79100 and 79400 in relation to the new code, and believed that the specialty society's median survey results provided the correct rank order between the two services. In addition, the RUC understood that an E/M code could not be billed in conjunction with 79403. The RUC thought the survey results reflected the physician work involved for this service, and believes this new service would have proper rank order within the family of codes with a relative work value of 2.25. **The RUC recommends a work relative value of 2.25 for CPT code 79403.**

***Practice Expense***

The RUC reviewed in-office practice expense recommendations for CPT code 79403 and the RUC believed that they were typical for the services provided. The RUC accepted the practice expense recommendations for 79403 without modification. In addition, the specialty requested that the practice expense relative value and non-physician work pool designation for code 79403 be crosswalked to CPT Code 78306.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲ 79100	JJ1	Radiopharmaceutical therapy, polycythemia vera, chronic leukemia, each treatment <u>by intravenous injection</u>  (For monoclonal antibody therapy, see code 79403)	XXX	1.32  (no change)
▲ 79400	JJ2	Radiopharmaceutical therapy, nonthyroid, nonhematologic <u>by intravenous injection</u>  (For monoclonal antibody therapy, see code 79403)	XXX	1.96  (no change)
● 79403	JJ3	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion  (For pre-treatment imaging, see 78802, 78804)  (Do not report code 79403 in conjunction with code 79400)	XXX	2.25

CPT Code: 79403

Tracking No: JJ3

Global: XXX

Recommended RVW: 2.25

**Descriptor:** Radiopharmaceutical therapy by intravenous infusion of radiolabeled monoclonal antibody

(For pre-treatment imaging, see 78802, 78804)

(Do not report 79403 in conjunction with 79400)

---

### Clinical Description of Service

#### Vignette Used in Survey (typical patient):

Typical patient: A 62-year-old man with long standing histologically confirmed B-cell Non-Hodgkins Lymphoma has relapsed with fever and pain, and has tumor recurrence confirmed by chest x-ray and CT studies. He has failed other prior radiation and chemotherapy treatment.

Note: Do not include E/M services leading to the determination that treatment is indicated, radiopharmaceutical distribution (pretreatment evaluation), infusion of unlabeled monoclonal antibody or medical physics services in the valuation of 79403.

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

#### Description of Pre-Service Work:

- Review interim studies, and change in clinical condition since initial consultation and pretreatment imaging, and dosimetry if performed
- Order radiopharmaceutical dosage to be administered
- Provide instruction to the patient and family regarding the infusion, potential immediate reactions, potential radiation exposure to family friends and the public, and obtain signed consent

#### Description of Intra-Service Work

- Regulatory documentation, review and oversight for ordering and administering radioactive materials
- Evaluate for adequate IV access
- Personally supervise infusion of the labeled monoclonal antibody, paying particular attention for possible immune reaction
- Discharge patient with instructions including about contact with family and the public and handling of bodily fluids
- Dictate report for medical record
- Communicate and arrange follow up observation and care with the referring physician

#### Description of Post-Service Work

- Review and sign report
- Regulatory documentation, review and oversight for disposal of radioactive materials

**SURVEY DATA**

<b>Presenter(s):</b>	Bibb Allen, Jr., M.D. (ACR), Michael A. Wilson, M. D. (SNM), and Kenneth A. McKusick, M.D. (SNM)					
<b>Specialty(s):</b>	American College of Radiology, Society of Nuclear Medicine					
<b>CPT Code:</b>	79403					
<b>Sample Size:</b>	167	<b>Resp n:</b>	19	<b>Resp %:</b>	11%	
<b>Sample Type:</b> Random						
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		1.00	2.03	2.25	2.54	3.50
<b>Pre-Service Time</b>				30.00		
<b>Pre-Service Evaluation Time:</b>						
<b>Pre-Service Positioning Time:</b>						
<b>Pre-Service Scrub, Dress, Wait Time:</b>						
<b>Intra-Service Time:</b>		5.00	20.00	30.00	40.00	240.00
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	15.00					
<b>Critical Care time/visit(s):</b>						
<b>Other Hospital time/visit(s):</b>						
<b>Discharge Day Mgmt:</b>						
<b>Office time/visit(s):</b>						

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

CPT	Descriptor	2003 RVW	Glob
79030	Radiopharmaceutical ablation of gland for thyroid carcinoma	2.10	XXX

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE:**

	Svy CPT	Ref CPT
<b>TIME ESTIMATES (MEDIAN)</b>		
Pre-service	30.00	
Intra-service	30.00	92 (Harvard)
Same Day Immediate Post-service	15.00	
Critical care		
Other hospital visit		
Discharge day management		
Office visit		
<b>TOTAL TIME</b>	75.00	92 (Harvard)
<b>INTENSITY/COMPLEXITY MEASURES (mean)</b>		
Survey Count		10
<b>TIME SEGMENTS</b>		
Pre-service	4.10	3.44
Intra-service	4.30	3.44
Post-service	3.00	2.33
<b>MENTAL EFFORT AND JUDGMENT</b>		
The number of possible diagnosis and/or the number of management options that must be considered	3.30	3.10
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.20
Urgency of medical decision making	3.20	2.50
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>		
Technical skill required	3.60	2.90
Physical effort required	2.90	2.30
<b>PSYCHOLOGICAL STRESS</b>		
The risk of significant complications, morbidity and/or mortality	4.40	3.30
Outcome depends on the skill and judgment of physician	4.00	3.40
Estimated risk of malpractice suit with poor outcome	4.00	3.50

**ADDITIONAL RATIONALE**

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

A consensus panel consisting of physicians from the American College of Radiology and Society of Nuclear Medicine was formed. They reviewed the survey data and recommend the survey median RVW of 2.25.

**Services Reported with Multiple CPT Codes**

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

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

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

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

**FREQUENCY INFORMATION**

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

New procedure.

**How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty Radiology X Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_  
 Specialty \_\_\_\_\_ \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_

**For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.**

Specialty Radiology Frequency 9,000  
 Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty Radiology Frequency 4,500  
 Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

CPT Code: 79403

Specialty Society('s) SNM/ACR

**AMA/Specialty Society Update Process  
RUC Summary of Recommendation  
XXX Global Period  
In Office Direct Inputs**

Sample Size: 26      Response Rate: (%): 100      Global Period: XXX

Tracking Number: JJ3      Reference Code 1 78306      Reference Code 2 \_\_\_\_\_

Geographic Practice Setting %: Rural 0%      Suburban 100%      Urban 0%

Type of Practice %:      0% Solo Practice  
                                  50% Single Specialty Group  
                                  50% Multispecialty Group  
                                  0% Medical School Faculty Practice Plan

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

Practice Expense was derived from data collected in previous surveys and the building block methodology used for nuclear medicine codes previously approved by the PEAC.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Confirm appropriateness of procedure with physician; confirm technique to be used, obtain physician written directive, determine radiopharmaceutical dose, and order the radiopharmaceutical from the commercial central pharmacy.
- Prepare radiopharmaceutical delivered by central pharmacy with NRC and DOT required check-in of RP, survey package, wipe test of package and recording all. Ready dose for potential infusions/injection with in-house labels and records, and later resurvey and arrange disposal of syringe
- Coordinate the administration of the therapy (radioactive) antibody infusion which follows within 4 hours of the IV infusion of "cold" Rituximab (Oncologist), requiring modification of schedule and personnel.

Intra-Service Clinical Labor Activities:

- Obtain RP dose from radiopharmaceutical receiving and storage area, reassy and record dose data, ensure dose would be appropriate for the patient based on the written directive (correct test and patient weight)
- Take patient to injection/infusion area, set up IV; assist physician during drug therapy infusion to include monitoring vital signs, preparation and assistance during possible medical emergency/ antibody murine reaction (oxygen, crash cart)
- Education/Instruction/Counseling as patient is taken back to waiting area after therapy session with emphasis on radiation risk to those at home; discharge patient
- Specific room clean up of injection/infusion area with defacement of labels, and required NRC survey and monitoring tasks

CPT Code: 79403  
Specialty Society('s) SNM/ACR

Post-Service Clinical Labor Activities:

- Regulatory compliance – NRC required wipe tests and surveys of area used, and documentation

CPT Code: 79403

Specialty Society('s) SNM/ACR

Total Staff Time In Office: **95 minutes**

Visits in Global Period: **Visits - (Therapy Injection)**

HCFA's Staff Type Code*	Clinical Labor	Total Pre-Service Time	Total Service Period (Day of service)	Total Post-Service Time After Day of Service)	Total Pre-Service, Service, and Post Service Time	Cost Estim. and Source applicable)
1023	Nuclear Medicine Technologist (Nuc Med Tech)	36	55	4	95	

\* From HCFA's Labor, Medical Supply, and Equipment List for year 2002. If not listed, provide full description, estimated cost, and cost source.

CMS Medical Supply Code*	Medical Supplies	Radiopharmaceutical Therapy	Units	Cost Estimate and Source (if applicable)
11302	Gloves, non-sterile	1	pair	
11102	Chux	1	each	
xxxxx	QC Wipes	5	each	\$0.13*
53003	Alcohol swabs	1	each	
91106	Angiocath with heplock	1	each	
91111	Stop cock, 3-way	1	each	
31502	Band aid	1	each	
11102	Chux	1	each	
31506	Gauze, 2x2	1	each	
11302	Gloves, non-sterile	1	each	
53062	Saline, 30 ml	1	each	
53090	Heparin flush	1	each	
91415	Syringe, 3 cc	0	each	
91407	Syringe, 10 cc	1	each	
91402	Needles, 19-25 g	1	each	
11139	Paper, table	0	each	
11112	Pillow case – disposable	0	each	
11106	Drape sheet	0	each	
73404	Film 8x10	0	each	
73423	Film developer/cost/exposure	0	each	
xxxxxx	Film Jacket (10x12) for scan	0	each	\$0.28*

\* From HCFA's Labor, Medical Supply, and Equipment List for year 2002. If not listed, provide full description, estimated cost, and cost source.

CMS Equipment Code*	Medical Equipment	Radiopharmaceutical Therapy	Units	Cost Estimate and Source (if applicable)
<b>Radiopharmaceutical Receiving</b>				
E51064	Dose Calibrator	95 min	1	
xxxxx	Dedicated pharmacy computer and printer	95 min	1	\$20,295*
xxxxx	Calibration source vial set & check sleeves	95 min	1	\$1,505*
xxxxx	Autogama counter	95 min	1	\$26,637*
E53004	Survey meter	95 min	1	
xxxxx	L-Block Table Shield	95 min	1	\$725*
xxxxx	Syringe Shields & Lead Holders (6)	95 min	6	\$1,310*
xxxxx	Lead-lined radioactive waste & lead-lined Sharps box	95 min	1	\$935*
xxxxx	Lead Shielding	95 min	1	\$2,150*
xxxxx	Y-90 Syringe Shields (2)	95 min	1	\$135*
	Y-90 Dose Injector, Manual	95 min	1	\$595*
<b>Injection Room</b>				
xxxxx	Phlebotomy-Injection Chair	0	0	
xxxxx	Bed	95 min	1	\$4660*
E91001	IV Infusion Pump	95 min	1	
<b>Imaging Area</b>				
E53020	Single/dual head camera, imaging table, computer & software	0	0	
E53004	Co-57 Flood Source	0	0	
E51002	Film Processor	0	0	
E51001	View Boxes	0	0	
xxxxx	Physician Analysis & View Station	0	0	
xxxxx	Medium Energy Collimator	0	0	

\* Catalog information and pricing provided to CMS following the January 2002 PEAC Meeting

\*\* Siemen's Catalog #05232868

**Type of Service: Evaluation/Management Services or Diagnostic Tests  
XXX Global Period**

**SITE OF SERVICE: In-Office**  
**Clinical Services**

	<b>Radiopharmaceutical Therapy</b>	<b>Total Minutes</b>	
<b>Pre-Service Period</b>			
<i>Start: When appointment for service is made</i>			
Confirm appropriateness of procedure with physician; confirm technique to be used, obtain physician written directive, determine radiopharmaceutical dose, and order the radiopharmaceutical from the central commercial pharmacy.	8	8	Nuc Med Tech
<b>Other Clinical Activity (please specify)</b>			
Prepare radiopharmaceutical delivered by central pharmacy with NRC and DOT required check-in of RP, survey package, wipe test of package and recording all. Ready dose for potential injection with in-house labels and records, and later resurvey and arrange disposal of syringe.	13	13	Nuc Med Tech
Coordinate the administration of the therapy (radioactive) antibody infusion which follows within 4 hours of the IV infusion of "cold" Rituximab (Oncologist), requiring modification of schedule and personnel	15	15	Nuc Med Tech
<i>End: Patient arrival at office for service</i>			
<b>Total Pre-Service Time</b>	<b>36</b>	<b>36</b>	

**Service Period**

**Start: Patient arrival at office for service**

<b>Radiopharmaceutical Therapy</b>	<b>Total Minutes</b>
--	--------------------------

**Intra-service**

Greet patient/provide gowning if appropriate, and take to injection or imaging area.	0	0	Nuc Med Tech
Obtain vital signs	0	0	
Prepare room, equipment, supplies, and set up protocol and change collimator on imaging device for each image session.	0	0	Nuc Med Tech
Prep and position patient in scanner while explaining scan for imaging session.	0	0	Nuc Med Tech
Prepare infusion/injection room, equipment and supplies	2	2	Nuc Med Tech
Obtain RP dose from radiopharmaceutical receiving and storage area, reassay and record dose data, ensure dose would be appropriate for the patient based on the written directive (correct test and patient weight).	7	7	Nuc Med Tech
Take patient to injection area, set up IV, infuse/inject radiopharmaceutical, review radiation risks	10	10	Nuc Med Tech
Assist physician during drug therapy infusion to include monitoring vital signs, preparation and assistance during possible medical emergency/antibody murine reaction (oxygen, crash cart)	22	22	Nuc Med Tech
Education/Instruction/Counseling as patient is taken back to waiting area after therapy session with emphasis on radiation risk to those at home; discharge patient	10	10	Nuc Med Tech
Coordinate home or outpatient care	0	0	
Clean room/equipment after each scan session	0	0	Nuc Med Tech
Specific room clean up of injection area with defacement of labels, and required NRC survey and monitoring tasks.	4	4	Nuc Med Tech
Other Clinical Activity (please specify)			

CPT Code: 79403  
Specialty Society('s) SNM/ACR

**End: Patient leaves office**

<b>Total Service Time</b>	<b>55</b>	<b>55</b>	<b>Nuc Med Tech</b>
---------------------------	-----------	-----------	---------------------

**Post-Service Period**

Start: Patient leaves office

Other Activity (please specify)

Regulatory compliance-NRC required wipe tests  
and surveys of areas used, and documentation

<b>4</b>	<b>4</b>	<b>Nuc Med Tech</b>
----------	----------	---------------------

**End: Last visit before end of global period**

**Total Post-Service Time**

<b>4</b>	<b>4</b>
----------	----------

**April 15, 2003 (BU)**

PEAC Codes 79403			
AMA/Specialty Society RUC Recommendation		CPT 78306	CPT 79403
(*) Modified and/or Specific to Nuclear Medicine	HCFA STAFF TYPE, MEDICAL SUPPLY OR EQUIPMENT CODE	78306 Bone Whole Body Planar Single Imaging Session	795XX Radiopharmaceutical therapy by intravenous infusion of radiolabeled monoclonal antibody
LOCATION		In Office	In Office
GLOBAL PERIOD			
TOTAL CLINICAL LABOR TIME		121	95 min
PRE-SERVICE			Therapy
Start: Following visit when decision for surgery or procedure is made.			
(*) Review X-ray, scan, lab, and past tests to confirm appropriateness of of procedure with physician, confirm technique to be used and any special views required, obtain physician written directive, determine radiopharmaceutical dose, and order the radiopharmaceutical from the commercial central pharmacy	NMT	8	8
(*) Other Clinical Activity (please specify)			
QC Planar Equipment to be used in scan	NMT	4	0
Prepare radiopharmaceutical delivered by central pharmacy with NRC and DOT required check-in of RP, survey package, wipe test of package and recording all Ready dose for potential infusion/injection with in-house labels and records, and later resurvey and arrange disposal of synnge	NMT	13	13
Coordinate the administration of the therapy (radioactive) antibody infusion which follows within 4 hours of the IV infusion of "cold" Rituximab (Oncologist), requiring modification of schedule and personnel	NMT		15
<b>Total Pre-Service Time</b>	<b>NMT</b>	<b>25</b>	<b>36</b>
End: Patient enters office for surgery/procedure			
SERVICE PERIOD			
Start: When patient enters office for surgery/procedure			
Review charts			
(*) Greet patient, provide gowning if appropriate, and take to imaging area for imaging session(s)	NMT	3	0
Obtain vital signs	NMT	0	0
(*) Prepare room, equipment, supplies, and set up protocol and change collimator on imaging device for each imaging session	NMT	2	0
(*) Prep and position patient in scanner while explaining scan for imaging session	NMT	3	0
(*) Prepare infusion/injection room, equipment, and supplies	NMT	0	2
Assist physician during drug therapy infusion to include monitoring vital signs, preparation and assistance during possible medical emergency/antibody immune reaction (oxygen, crash cart)	NMT		22
(*) Education/Instruction/Counseling as patient is taken back to waiting area after each scanning/therapy session with emphasis on radiation risk to those at home Discharge patient	NMT	3	10
(*) Coordinate home or outpatient care	NMT	0	0
(*) Clean scan rooms/equipment after each scanning session	NMT	3	0
(*) Specific room clean up of injection area with defacement of labels, and required NRC survey and monitoring tasks	NMT	4	4

PEAC Codes 79403			
AMA/Specialty Society RUC Recommendation		CPT 78306	CPT 79403
(*) Modified and/or Specific to Nuclear Medicine	HCFA STAFF TYPE, MEDICAL SUPPLY OR EQUIPMENT CODE	78306 Bone Whole Body Planar Single Imaging Session	795XX Radiopharmaceutical therapy by intravenous infusion of radiolabeled monoclonal antibody
Other Clinical Activity (please specify)			
(*) Obtain RP dose from radiopharmaceutical receiving and storage area, reassay and record dose data, ensure dose would be appropriate for the patient based on the written directive (correct test and patient weight)	NMT	7	7
(*) Take patient to injection area, set up IV, infuse/inject radiopharmaceutical, review radiation risks	NMT	10	10
(*) Acquire images and review each set of raw data for completeness, include time between acquisition of images (1 min)	NMT	42	0
Approval of Images		0	0
<b>Service Period Total</b>	<b>NMT</b>	<b>77</b>	<b>55</b>
<b>End: Patient leaves office</b>			
<b>Post-Service Period</b>			
<b>Start: Patient leaves office</b>			
Other Activity (please specify)			
(*) Post processing of raw data into final format, development of hard copy, archiving and obtain approval as to quality of study and ability to discharge patient	NMT	15	0
(*) Regulatory compliance –NRC required wipe tests and surveys of areas used, and documentation	NMT	4	4
<b>Post Service Total</b>	<b>NMT</b>	<b>19</b>	<b>4</b>
<b>End: With last office visit before end of global period</b>			
<b>MEDICAL SUPPLIES</b>			
<b>Radiopharmaceutical -Storage &amp; Receiving</b>			
11302 Gloves, non-sterile	11302	1	1
11102 Chux	11102	1	1
XXXXX QC Wipes	* \$0.13 ea	5	5
<b>INJECTION AREA</b>			
Alcohol Swabs	53003	1	1
Angiocath with heplock	91106	1	1
Stop cock, 3 way	91111	1	1
Band aid	31502	1	1
Chux	11102	1	1
Gauze, 2x2	31506	1	1
Gloves, non-sterile	11302	1	1
Saline 30 ml	53062	1	1
Hepann flush	53090	1	1
Synnge, 3cc	91415	0	0
Synnge, 10cc	91407	1	1
Needles, 19-25 g	91402	1	1
<b>IMAGING AREA</b>			
Paper, table	11139	7 Feet	0
Pillow case - disposable	11112	1	0
Drape sheet	11106	1	0
Film 8x10	73404	1	0
Film developer/ cost per exposure	73423	1	0
Film Jacket (10x12 inch) for this scan	* \$0.28 ea	1	0
* From HCFA's Labor, Medical Supply, and NM Equipment List for year 2000 If not listed, provide full description, estimated cost, and cost source			
<b>Equipment</b>			
<b>Radiopharmaceutical Receiving Area</b> (This is a fixed room for future codes)			
Dose Calibrator	E51064	121 min	95 min
Dedicated pharmacy computer and printer	* \$20,295	121 min	95 min
Calibration Source Vial Set & Check Sleeves	\$1,505	121 min	95 min
Autogamma Counter	** \$26,637	121 min	95 min
Survey meter	E53004	121 min	95 min
L-Block Table Shield	* \$725	121 min	95 min

PEAC Codes 79403			
AMA/Specialty Society RUC Recommendation		CPT 78306	CPT 79403
(*) Modified and/or Specific to Nuclear Medicine	HCFA STAFF TYPE, MEDICAL SUPPLY OR EQUIPMENT CODE	78306 Bone Whole Body Planar Single Imaging Session	795XX Radiopharmaceutical therapy by intravenous infusion of radiolabeled monoclonal antibody
Syringe Shields & Lead Pig Holders (6)	* \$1,310	121 min	95 min
Lead-lined radioactive waste and lead lined Sharps box	* \$935	121 min	95 min
Lead shielding	* \$2,150	121 min	95 min
Y-90 Syringe Shields (2)	\$0	0	95 min
Y-90 Dose Injector, Manual	\$595	0	95 min
<b>Injection Room</b>			
(This is a fixed room for future codes)			
Phlebotomy-Injection Chair	* \$519	121 min	0
Bed	\$4,660	0	95 min
IV Infusion Pump	E91001	0	95 min
<b>Imaging Area</b>			
(This is a fixed room for future codes)			
Single/dual head camera, Imaging Table, computer and software	E53020	96 min	0
Co-57 flood source	E53004	96 min	0
Film processor	E51002	96 min	0
View Boxes	E51001	96 min	0
Physician Analysis & Viewing Station	* \$35,000	96 min	0
Medium Energy Collimator (Siemens catalog #05232868)	* \$14,200		0
Information provided to CMS January 2002 PEAC Meeting			

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2003

**Comprehensive Coagulation Assessment**

CPT created a new code 85396 (*Coagulation/fibrinolysis assay, whole blood (eg. viscoelastic clot assessment), including use of any pharmacologic additives(s), as indicated, including interpretation and written report, per day*) to describe a relatively uncommon service that is performed to assess the integrity of the hemostatic system in a patient with a significant bleeding problem. The code is used during procedures such as liver transplant, cardiac services, and in the ICU. It was predicted that due to the reporting requirements, anesthesia would not be a large provider of this service and would be used mostly by pathology. In the future, however, it is likely that utilization of this service will increase as its utility is appreciated and more physicians become comfortable with interpretation.

The RUC discussed in detail the possibility of billing multiple times for this code and determined that the value should be based on a single coagulation episode. Discussion with the presenters indicated that each interpretation performed in a series requires review of the previous tests, increasing the work proportionally. This mitigates the concern about declining pre-service work when the test is performed multiple times. The number of times the test can be performed and billed is of concern, but the RUC deemed this issue as primarily a payment policy issue, not a valuation issue. Decisions about multiple tests may be required in a given patient and should be based on medical necessity. The RUC believes that review of utilization may be required prior to setting any limitations on use. The RUC does not recommend adding additional language in CPT to limit the use of the codes.

The RUC compared the code to two reference codes, 88180 (*Flow cytometry; each cell surface, cytoplasmic or nuclear marker work RVU, 0.36, physician total time of 25 minutes*) and CPT code 85390 (*Fibrinolysins or coagulopathy screen, interpretation and report work RVU 0.37, physician total time of 35 minutes*). The RUC agreed that the ASA surveyed time totaling 35 minutes should be used in spite of the low response rate. The committee felt that the comparison of work with code 85390 is equivalent given the same total time estimates and an examination of work involved. The committee agreed that the value of 0.37 is appropriate and accurately captures the work involved in this procedure.

The RUC requested that the CPT Editorial Panel revise the code to specify that the services included in the procedure include the use of any pharmacologic additive(s), as indicated, including interpretation and written report, per day.

**The RUC recommends a work RVU of 0.37 for code 85396.**

**Practice Expense**

There are no direct inputs for this code.

CPT Code (•New)	Track ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
•85396	Q1	Coagulation/fibrinolysis assay, whole blood (eg. viscoelastic clot assessment), including use of any pharmacologic additives(s), as indicated, including interpretation and written report, per day	XXX	0.37

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

CPT Code: 85396 Tracking Number: Q1 Global Period: XXX RUC Recommended RVW = **0.37** ~~0.47~~

CPT Descriptor: Coagulation/fibrinolysis assay, whole blood (eg. viscoelastic clot assessment), including use of any pharmacologic additives(s), as indicated, including interpretation and written report, per day

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 70 year old male in ICU with hemostatic dysfunction, post status coronary artery bypass graft with history of liver disease. Coagulation screening tests show elevated PT, moderately elevated D-Dimer, decreasing fibrinogen and decreasing platelet counts.

Description of Pre-Service Work: Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the TEG result.

Description of Intra-Service Work: Interpretation of the TEG; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; dictation of the interpretation report.

Description of Post-Service Work: Report finalization; post-interpretation verbal communications with other professionals, patient, family; arranging for further studies.

**SURVEY DATA**

<b>Presenter(s):</b>	Cheryl Hirsch-Ginsberg, MD, University of Texas MD Anderson Cancer Center				
<b>Specialty(s):</b>	College of American Pathologists, American Society of Anesthesiologists				
<b>CPT Code:</b>	85396 Coagulation/fibrinolysis assay, whole blood (eg. viscoelastic clot assessment), including use of any pharmacologic additives(s), as indicated, including interpretation and written report, per day				
<b>Sample Size:</b>	CAP: 14 ASA: 13	<b>Resp n:</b> CAP: 13 ASA: 8	<b>Resp %:</b> CAP: 93% ASA: 62%		
<b>Sample Type:</b>	Panel - Few physicians perform TEG interpretations at this time				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW: CAP</b>	0.60	0.75	<b>0.94</b>	0.94	1.00
<b>Survey RVW: ASA</b>	0.37	0.38	<b>0.39</b>	0.51	0.75
<b>Pre-Service Time: CAP</b>	0.00	5.00	<b>8.08</b>	10.00	20.00
<b>Pre-Service Time: ASA</b>	0.00	5.00	<b>10.00</b>	15.00	30.00
<b>Intra-Service Time: CAP</b>	4.00	7.00	<b>10.00</b>	15.00	20.00
<b>Intra-Service Time: ASA</b>	0.00	10.00	<b>12.50</b>	30.00	240.00
<b>Post-Service Time: CAP</b>	0.00	4.00	<b>10.00</b>	10.00	25.00
<b>Post-Service Time: ASA</b>	5.00	10.00	<b>12.50</b>	15.00	30.00

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
CAP: 86077	Blood bank physician services: difficult cross-match and/or evaluation of irregular antibody(s), interpretation and written report	XXX	0.94
ASA: 85390	Fibrinolysins or coagulopathy screen, interpretation and report	XXX	0.37

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

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

**TIME ESTIMATES (Median)**

	<u>New/Revis. CPT Code: 85396: CAP</u>	<u>Key Reference CPT Code: 86077: CAP</u>	<u>New/Revis. CPT Code: 85396:ASA</u>	<u>Key Reference CPT Code: 85390: ASA</u>
Median Pre-Service Time		0.00	10.00	8.00
Median Intra-Service Time		40.00	12.50	17.00
Median Immediate Post-service Time		0.00	12.50	10.00
Median Critical Care Time				
Median Other Hospital Visit Time				
Median Discharge Day Management Time				
Median Office Visit Time				
Median Total Time		40.00	35.00	35.00

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.15	3.85	3.88	3.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.62	3.77	3.63	3.00
Urgency of medical decision making	4.54	3.62	4.38	3.88

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.77	3.54	3.00	2.25
Physical effort required	2.54	2.23	2.38	2.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.23	4.15	2.00	3.00
---	------	------	------	------

Outcome depends on the skill and judgement of physician	4.08	4.00	3.38	3.25
Estimated risk of malpractice suit with poor outcome	3.69	3.85	2.50	2.63

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**  
**885396:**  
**CAP**

**Reference**  
**Service**  
**86077: CAP**

**CPT Code**  
**85396: ASA**

**Reference**  
**Service**  
**85390: ASA**

**Time Segments (Mean)**

Pre-Service intensity/complexity	2.62	2.69	2.75	2.50
Intra-Service intensity/complexity	3.69	3.85	3.63	3.00
Post-Service intensity/complexity	3.08	2.92	3.13	3.00

**ADDITIONAL RATIONALE**

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

*Data from the CAP and ASA surveys were considered by both specialties. The CAP agreed that, although the survey data from pathologists selected the 86077 as the reference service, the work involved in TEG interpretation is closer to, but more difficult than, that involved with interpretation of a fibrinolysis screen, that has a RVW of 0.37. The TEG generates a dynamic real-time tracing of the clot, from formation to degradation, and in so doing includes more information about the clot than the numbers obtained in other tests solely designed to screen for fibrinolytic activity. This causes the work involved in TEG interpretation to be about 125% of that for fibrinolysis screen interpretation. This places the RVW for TEG at 0.47, which is the mean ASA survey RVW value.*

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

---

---

**FREQUENCY INFORMATION**

How was this service previously reported? Not reported (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Pathology \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes X Rarely

Specialty Anesthesiology \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes X Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology Frequency Fewer than 2500 reported by all respondents, range 5 - 850

Specialty Anesthesiology Frequency Fewer than 1000 reported by all respondents, range 10-300

**Estimate fewer than 20,000 services nationwide per year with new code.**

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

Specialty Pathology Frequency Estimate fewer than 5,000

Specialty Anesthesiology Frequency Estimate fewer than 5000

Do many physicians perform this service across the United States? \_\_\_\_\_ Yes X No

---

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Cytopathology, Selective Cellular Enhancement Technique**

***Work Recommendations***

New code 88112 *Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal (Do not report 88112 with 88108)* has been created to encompass the new technology based on the Pap thinprep technique which provides for cell enrichment with concentration of specimens yielding more material for review with better preservation and more expanded application than were available based on smear preparations (88104 *Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation* (Work RVU = 0.56)) or traditional cytoconcentrates (cytospin billed as 88108 *Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)* (Work RVU = 0.56).

The specialty society explained that the relative work values of CPT codes 88104 and 88108 do not encompass the scope, intensity and impact of the service provided in the new CPT code 88112. These existing codes do not accurately capture the new cellular enhancement technologies, in the new code, that allows both concentration and enrichment of cytology specimens. Cytology specimens can be used on complicated specimens that could not be evaluated with typical concentration techniques.

The RUC reviewed the specialty society recommendations, survey results, and work values of other codes within the family of new CPT code 88112. The RUC understood that the new code allows the physician to review approximately 10,000 cells per slide, whereas codes 88104 and 88108 entails the review of less than 1,000 cells per slide. The median survey results support a work relative value of 1.20, however the specialty society indicated that the mean relative value of the survey (1.18 RVUs) would be more appropriate. The RUC believed that the new service required more physician time and a higher level of intensity than 88104 and 88108 from the specialty society's survey data and presentation, and supported the value as presented. **The RUC recommends a work relative value of 1.18 for CPT code 88112.**

***Practice Expense Recommendation***

Attached are the direct practice expense inputs for new code 88112 reflecting a RUC change in the clinical staff type for some of the clinical activities.

<b>CPT Code (•New)</b>	<b>Track ing Num- ber</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Work RVU Recommendation</b>
•88112	KK1	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal (Do not report 88112 with 88108)	XXX	1.18

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

CPT Code: 88112 Tracking Number: KK1 Global Period: XXX Recommended RVW: 1.18

CPT Descriptor: **Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal (Do not report 88112 with 88108)**

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: **Cytopathologic examination of common bile duct brushings obtained during endoscopic retrograde cholangiopancreatography. The brush has been rinsed and transported in a liquid medium (eg, CytoLyt®, CytoRich®, RPMI). The material has been prepared by concentration and enrichment (eg, Surepath™, ThinPrep™) and delivered to the pathologist for interpretation.**

Percentage of Survey Respondents who found Vignette to be Typical: **90%**

Description of Pre-Service Work: *Obtaining and reviewing the history and selected diagnostic studies, including examination of previous study reports prior to examining the specimen; review of literature or research and communicating with other professionals prior to interpretation of the material.*

Description of Intra-Service Work: *Obtaining and reviewing the results of other diagnostic studies, including examination of previous/additional slides or reports, during the interpretation of the specimen; examination of the slide and cellular material; comparison to previous study reports; identification of clinically meaningful findings; consultation with other pathologists regarding the specimen; any review of literature or research during examination of the specimen; any dictation or report preparation performed during examination of the specimen.*

Description of Post-Service Work: *Report preparation and finalization; written and telephone communications with other professionals, and patients; arranging for further studies or other services.*

**SURVEY DATA**

<b>Presenter(s):</b>	<b>Susan E. Spires, MD, FCAP, Lexington, KY</b>				
<b>Specialty(s):</b>	<b>College of American Pathologists</b>				
<b>CPT Code:</b>	88112 Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal				
<b>Sample Size:</b> 35	<b>Resp n:</b> 31	<b>Resp %:</b> 89%			
<b>Sample Type:</b> Panel					
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.84	1.10	<b>1.20</b>	1.35	1.50
<b>Pre-Service Time:</b>	0	5	<b>8</b>	10	12
<b>Intra-Service Time:</b>	6	15	<b>25</b>	30	40
<b>Post-Service Time:</b>	1	6	<b>10</b>	10	20

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
88173	Cytopathology, evaluation of fine needle aspirate; interpretation and report	XXX	1.39

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

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

Number of respondents who choose Key Reference Code: 22 of 31

<u>TIME ESTIMATES (Median)</u>	New/Revis. CPT Code: <u>88112</u>	Key Reference CPT Code: <u>88173</u>
Median Pre-Service Time	8	15
Median Intra-Service Time	25	25
Median Immediate Post-service Time	10	10
Median Critical Care Time		
Median Other Hospital Visit Time		
Median Discharge Day Management Time		
Median Office Visit Time		
<b>Median Total Time</b>	<b>43</b>	<b>50</b>

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.27	4.09
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.36
Urgency of medical decision making	4.09	3.77

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.50	3.32
Physical effort required	2.59	2.50

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.73	4.32
---	------	------

Outcome depends on the skill and judgement of physician	4.77	4.32
---	------	------

Estimated risk of malpractice suit with poor outcome	4.55	4.09
--	------	------

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.27	2.86
----------------------------------	------	------

Intra-Service intensity/complexity	4.45	3.77
------------------------------------	------	------

Post-Service intensity/complexity	3.80	3.23
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

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

Following the survey, representatives of the cytopathology community and the general pathology community reviewed the data and agreed that the mean survey value of 1.18 is an appropriate RWV for the 88112. The median survey time for 88112 (43 minutes) is 86% of the RUC time for the key Reference Service (88173, 50 minutes) and the recommended RWV is 84% of the RWV of 1.39 for the Reference Service .

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

---

**FREQUENCY INFORMATION**

How was this service previously reported? 88108 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Pathology \_\_\_\_\_ Commonly X Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty \_\_\_\_\_ Pathology \_\_\_\_\_ Frequency Unknown, respondents reported variable frequencies, ranging from 10 times per year to 3600 per year.

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty \_\_\_\_\_ Pathology \_\_\_\_\_ Frequency \_\_\_\_\_ Not known \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Do many physicians perform this service across the United States? \_\_\_\_\_ Yes X No

---

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
Pathology Codes  
Direct Inputs**

CPT Long Descriptor: Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal

Sample Size: No Survey Response Rate: (%): \_\_\_\_\_  
Global Period: \_\_\_\_\_

Tracking Number: \_\_\_\_\_ Reference Code 1 \_\_\_\_\_ Reference Code 2 \_\_\_\_\_

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
\_\_\_\_\_ Single Specialty Group  
\_\_\_\_\_ Multispecialty Group  
\_\_\_\_\_ Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: **The CAP Practice Expense Work Group (12 pathologists with all geographic and practice arrangements represented and with representation of the American Society of Cytopathology) developed the initial recommendations for these codes. The data were then submitted to two other CAP committees for independent review. Total review included 32 pathologists from various practice types.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: **A laboratory technician or histotechnologist opens the specimen containers, confirms the patient identification, and collates requisition slips and slides on a per case basis. The lab information system is searched, the specimen logged in and tracking/reporting systems initiated, accession number assigned, and material labeled. Any missing or ineligible information is obtained/clarified. The technician records the material received and/or volume/appearance of liquid specimen. The material is batched, specimen preparations are made from liquid specimens (centrifugation or filter), filters and stains prepared, cassettes loaded with slides, and the stainer programmed. A cytotechnologist then retrieves the material, confirms the patient identification, verifies the information, reviews the patient history and organizes the slides for examination. The cytotech visually views the microscope slides for evidence of atypical cells.**

Intra-Service Clinical Labor Activities: **: The labtech or cytotech assembles the slides and delivers them to the pathologist.**

Post-Service Clinical Labor Activities: **After the pathologist examines the slides, the labtech reassembles them, puts them in folders, prints, prepares, packs and transports specimens for storage, disposes of remaining specimens, chemicals and other consumables and hazardous waste, and cleans the area. The cytotech enters quality assurance and workload data.**

Total Staff Time:

HCFA's Staff Type Code**	Clinical Labor	Pre-Service Time	Service Period	Coordination of Care*	Post-Service Time	Cost Estimate and Source (if applicable)
1018	Lab Technician	7			3	
14017	Histotechnologist	22.5				
1010	Cytotechnologist	23.5	0.5		2	

\*By staff during the service period – Expense Incurred by Practice.

\*\* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
92007	Microscope slide	2		
92002	Coverslip	2		
75016	Label	2		
	Alcohol, bottle (Fisher catalog 23-03-4803, \$101/100 bottles)	1		
	Biohazard specimen transporter bag (#ST0069, \$35/1000 GemMed Industries Inc, POB 2276, Ctystal Lake, IL 60039-2276)	1		
52312	Bleach	0.013 gal		
75001	Centrifuge tube	1		
75116	Clearing reagent	2 slide		
75128	CytoLyt Solution	1 oz		
75063	Disposable lab coat	1		
11124	Eye shield	1		
	Filter paper (18.5 cm Whatman Qualitative filter paper, Daigger HX 8351CA Pkg of 100, \$48.18)	2		
75127	Filter, specimen TransCyte non-gyn	2		
11302	Gloves, nonsterile	1		
75089	Mounting media	0.4 ml		
75128	PreservCyt Solution vial (Cytoc box of 50 vials \$40, 2000 price list)	1 oz		
	Slide mailer (5-slide size) (\$12.95/25, Daigger 2000 Catalog #HX15982,	1		

	www.daigge.com)			
<b>75125</b>	Stain, Diff Quick	<b>1 slide</b>		
<b>75126</b>	Stain, Pap non-gyn	<b>1 slide</b>		
<b>75070</b>	Transfer pipet 23ml	<b>2</b>		

\* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

<b>HCFA's Equipment Code*</b>	<b>Procedure Specific Medical Equipment</b>	<b>No. of units in practice</b>	<b>Cost Estimate and Source (if applicable)</b>
No Code	Biohazard hood	1	
E13601	Microscope, compound	1	
E13642	Robotic cover slipper	1	
E13645	Slide etcher	1	
E13648	Vortex mixer	1	
E13657	Cytology ThinPrep™ Processor	1	
E13644	Slide dryer oven	1	
E13649	Tissue processing fume hood	1	
E91003	Ventilator hood & blower	1	
E13643	Routine Pap stainer	1	

\* From HCFA's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

Type of Service: Pathology  
 XXX Global Period

<u>Clinical Services</u>	<u>Minutes</u>	<u>Staff Type – Circle</u>
<b>Pre-Service Period</b>		
<i>Start: When containers/requisitions prepared for physician.</i>		
Prepare specimen containers/preload fixative/label containers/distribute requisition form(s) to physician	<u>2 min</u>	Lab Technician
Accession of specimen/prepare for examination	<u>4 min</u>	Lab Technician
Perform screening function (where applicable)		
Other Clinical Activity (please specify)	<u>1 min</u>	Lab Technician
<hr/>		
<i>Other Clinical Activity (please specify) Process specimen for slide preparation (includes processing, embedding, sectioning and recuts, staining, coverslipping, quality control function, maintaining specimen tracking, logs and labeling).</i>	<u>22.5 min</u>	Histotech
<i>Other Clinical Activity (please specify) Retrieve prior material, confirm patient ID, organize work, verify and review history</i>	<u>7.5 min</u>	Cytotech
<i>Other Clinical Activity (please specify) Perform screening function</i>	<u>16 min</u>	Cytotech
<i>End: When specimen is ready for examination by pathologist.</i>		
<b>Service Period</b>		
<i>Start: When specimen is ready for examination by pathologist.</i>		
Assist pathologist with gross specimen examination (including performance of intraoperative frozen sections)	_____	Histotech, Cytotech, Lab Tech, Other _____
Prepare specimen for manual/automated processing	_____	Histotech, Cytotech, Lab Tech, Other _____
Process specimen for slide preparation (includes processing, embedding, sectioning and recuts, centrifugation, routine and special staining, coverslipping, quality control function, maintaining specimen tracking, logs and labeling)	_____	Histotech, Cytotech, Lab Tech, Other _____
Assemble and deliver slides with paperwork to pathologist	<u>0.5 min</u>	Cytotech
Clean room/equipment while performing	_____	Histotech, Cytotech, Lab Tech, Other _____
Coordinate Care	_____	Histotech, Cytotech, Lab Tech, Other _____
Other Activity (please specify)	_____	Histotech, Cytotech, Lab Tech, Other _____
<hr/>		
<i>End: When specimen examination by pathologist is complete.</i>		



AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Tumor Morphometry**

***Work Recommendation***

One CPT code was revised and another added to properly describe the different processes of immunocytochemistry and morphometric analysis being performed typically by pathologists. CMS had initially asked that CPT codes 88342 *Immunocytochemistry (including tissue immunoperoxidase), each antibody* and 88358 *Morphometric analysis; tumor (eg., DNA ploidy)* be reviewed by the CPT Editorial Panel to clarify the service(s) being provided.

The RUC reviewed revised code 88358 and new code 88361 *Morphometric analysis; tumor immunohistochemistry (e.g., Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody*. The RUC reviewed the specialty society's recommendation and survey results for both codes and did not accept the initial specialty society work value recommendations.

The initial recommendations by the specialty were for a Work RVU of 1.20 for CPT code 88358 and 1.35 RVUs for 88361. The RUC discussed the physician work of the two codes with the presenters, and agreed that the physician work for both codes were similar. With this in mind, the committee members believed that the specialty society's 25<sup>th</sup> percentile work survey results (0.95 for 88358 and 0.94 for 88361) more accurately reflected the physician work involved. The RUC members were satisfied with the median physician time components and believed the intra-service work per unit of time supported the recommended work RVUs.

RUC members reviewed code 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Work RVU = 0.94) for its physician time and intensity. The committee believed that these two codes were aligned properly at the survey's 25<sup>th</sup> percentile RVUs with respect to the physician work and intensity of code 86077.

The RUC recommends the following relative values that reflect the 25<sup>th</sup> percentile of the specialty's survey results:

**Work RVU = 0.95** - 88358 *Morphometric analysis; tumor (e.g. DNA ploidy)*

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

**Work RVU = 0.94** - 88361 *Morphometric analysis; tumor immunohistochemistry (e.g., Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody*

The specialty reassured the RUC that by now recommending a higher work RVU for 88358 than for 88361, a rank order anomaly would not be created. The specialty society representatives supported the recommendations of the RUC.

***Practice Expense Recommendation***

The RUC reviewed the practice expense direct inputs for these two codes and made the following changes to the specialty society’s recommendations:

- **The clinical labor time for both codes in the pre and post service time periods be designated as a Lab Technologist.**
- **The clinical labor time for CPT Code 88361 should be cross-walked to PEAC reviewed code 88342**  
*Immunocytochemistry (including tissue immunoperoxidase), each antibody*
- **Supplies were reduced for 88361:**
  - Coverslip was reduced from 7 to 5**
  - Label was reduced from 7 to 5**
  - Microscope slide was reduced from 6 to 3**

A complete list of practice expense items approved by the RUC is attached.

<b>CPT Code (•New)</b>	<b>Tracking Number</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Work RVU Recommendation</b>
88342		Immunocytochemistry (including tissue immunoperoxidase), each antibody  <u>(For quantitative or semiquantitative immunohistochemistry, use 88361)</u>	XXX	0.85  (no change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲88358	LL1	Morphometric analysis; tumor (e.g., DNA ploidy)  <u>(Do not report 88358 with 88313 unless each procedure is for a different special stain)</u>	XXX	0.95
●88361	LL2	tumor immunohistochemistry (e.g., Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody  (Do not report 88361 with 88342 unless each procedure is for a different antibody)	XXX	0.94

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

CPT Code: 88358 Tracking Number: LL1 Global Period: XXX Recommended RVW 0.95

CPT Descriptor: Morphometric analysis; tumor (e.g., DNA ploidy)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 54 year old female has previously been diagnosed with ductal carcinoma of the breast with axillary nodal metastasis identified on sentinel lymph node biopsy. The stained slides are analyzed by the pathologist, along with reference positive and negative samples, to determine if the staining process is interpretable and therefore warrants a semiquantitative or quantitative analysis. The stained slides are interpretable and DNA ploidy evaluation is therefore performed. A semiquantitative or quantitative interpretation is provided using a computer assisted methodology.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Pre-Service Work: Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test results.

Description of Intra-Service Work: Interpretation of the stained slides to determine if a semiquantitative/quantitative procedure is warranted. Interpretation of the DNA ploidy; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature of research during examination of the test results; any dictation or report preparation performed during examination of the test results.

Description of Post-Service Work: Report preparation and finalization for the stained slide study and the DNA ploidy; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports; arranging for further studies or other services.

**SURVEY DATA**

<b>Presenter(s):</b>	Lester E. Wold, MD, FCAP, Rochester, MN				
<b>Specialty(s):</b>	College of American Pathologists				
<b>CPT Code:</b>	88358 Morphometric analysis; tumor (e.g., DNA ploidy)				
<b>Sample Size:</b> 68	<b>Resp n:</b> 12	<b>Resp %:</b> 18%			
<b>Sample Type:</b> Panel					
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.40	0.95	1.20	1.42	1.73
<b>Pre-Service Time:</b>	0	5	8	11	20
<b>Intra-Service Time:</b>	10	10	20	23	30
<b>Post Service Time:</b>	1	5	10	10	30

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
88173	Cytopathology, evaluation of fine needle pirate; interpretation and report	XXX	1.39

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

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

Number of respondents who choose Key Reference Code: 8 of 12

**TIME ESTIMATES (Median)**

<u>New/Revis.</u>	<u>Key Reference</u>
<u>CPT Code:</u>	<u>CPT Code:</u>
<u>88358</u>	<u>88173</u>

<u>TIME ESTIMATES (Median)</u>	<u>New/Revis. CPT Code:</u>	<u>Key Reference CPT Code:</u>
Median Pre-Service Time	8	15
Median Intra-Service Time	20	25
Median Immediate Post-service Time	10	10
Median Critical Care Time		
Median Other Hospital Visit Time		
Median Discharge Day Management Time		
Median Office Visit Time		
<b>Median Total Time</b>	<b>38</b>	<b>50</b>

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.13	4.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.88	3.88
Urgency of medical decision making	3.25	4.38

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.13	4.25
Physical effort required	3.25	3.13

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.25	4.50
---	------	------

Outcome depends on the skill and judgement of physician	4.00	4.38
---	------	------

Estimated risk of malpractice suit with poor outcome	2.88	4.50
--	------	------

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.88	3.75
----------------------------------	------	------

Intra-Service intensity/complexity	4.38	4.25
------------------------------------	------	------

Post-Service intensity/complexity	3.25	3.25
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

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

Following the survey, representatives of the pathology community reviewed the data and agreed that the median survey value of 1.20 is an appropriate RVW for 88358.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

**FREQUENCY INFORMATION**

How was this service previously reported? \_\_\_\_\_ 88358 \_\_\_\_\_ (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty \_\_\_ Pathology \_\_\_\_\_ \_\_\_\_\_ Commonly  Sometimes \_\_\_\_\_ Rarely

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty \_\_\_ Pathology \_\_\_\_\_ Frequency\_\_

2000 frequency for 88358 was 35,753. However, frequency is expected to decrease with revisions to code. Survey respondents indicated frequency between 0 and 508 in the past year.

Specialty \_\_\_\_\_ Frequency\_\_\_\_\_

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

Specialty \_\_\_ Pathology \_\_\_\_\_ Frequency \_\_\_\_\_ Unknown\_

Specialty \_\_\_\_\_ Frequency\_\_\_\_\_

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

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

CPT Code: 88361 Tracking Number: LL2 Global Period: XXX Recommended RVW: 0.94

CPT Descriptor: Morphometric analysis; tumor immunohistochemistry (e.g., Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody

(Do not report 88361 with 88342 unless each procedure is for a different antibody)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 54 year old female has previously been diagnosed with ductal carcinoma of the breast with axillary nodal metastasis identified on sentinel lymph node biopsy. The stained slides are analyzed by the pathologist, along with reference positive and negative samples, to determine if the staining process is interpretable and therefore warrants a semiquantitative or quantitative interpretation. The immunoassay is positive and Her-2/neu evaluation is performed. A semiquantitative or quantitative interpretation is provided using a computer assisted methodology.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Description of Pre-Service Work: Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test results.

Description of Intra-Service Work: Interpretation of the stained slides to determine if a semiquantitative/quantitative procedure is needed. Interpretation of the Her-2/neu preparation; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature of research during examination of the test results; any dictation or report preparation performed during examination of the test results.

Description of Post-Service Work: Report preparation and finalization for the stained slides and the Her-2/neu; written and telephone communications with other professionals, patients and family; obtaining and reviewing the results of other diagnostic studies, including examination of previous slides or reports; arranging for further studies or other services.

**SURVEY DATA**

<b>Presenter(s):</b>	Lester E. Wold, MD, FCAP, Rochester, MN		
<b>Specialty(s):</b>	College of American Pathologists		
<b>CPT Code:</b>	88361, Morphometric analysis; tumor immunohistochemistry (e.g., Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative		
<b>Sample Size:</b> 68	<b>Resp n:</b> 17	<b>Resp %:</b> 25%	
<b>Sample Type:</b>	Panel		

	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.35	0.94	<b>1.35</b>	1.39	1.50
<b>Pre-Service Time:</b>	0	5	<b>10</b>	10	15
<b>Intra-Service Time:</b>	3	10	<b>15</b>	20	40
<b>Post-Service Time:</b>	1	5	<b>7</b>	10	30

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
88173	Cytopathology, evaluation of fine needle pirate; interpretation and report	XXX	1.39

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

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

Number of respondents who choose Key Reference Code: 11 of 17

**TIME ESTIMATES (Median)**

New/Revis.  
CPT Code: 88361      Key Reference  
CPT Code: 88173

Median Pre-Service Time	10	15
Median Intra-Service Time	15	25
Median Immediate Post-service Time	7	10
Median Critical Care Time		
Median Other Hospital Visit Time		
Median Discharge Day Management Time		
Median Office Visit Time		
<b>Median Total Time</b>	<b>32</b>	<b>50</b>

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.82	4.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.91
Urgency of medical decision making	3.91	4.45

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.36	4.09
Physical effort required	3.09	2.82
<b>Psychological Stress (Mean)</b>		
The risk of significant complications, morbidity and/or mortality	4.09	4.64
Outcome depends on the skill and judgement of physician	4.55	4.64
Estimated risk of malpractice suit with poor outcome	3.82	4.82

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.36	3.09
Intra-Service intensity/complexity	4.36	4.36
Post-Service intensity/complexity	3.18	3.18

---

**ADDITIONAL RATIONALE**

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

Following the survey, representatives of the pathology community reviewed the data and agreed that the median survey value of 1.35 is an appropriate RVW for 88361.

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.

- \_\_\_ Multiple codes are used to maintain consistency with similar codes.
- \_\_\_ Historical precedents.
- \_\_\_ Other reason (please explain) \_\_\_\_\_

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

---



---

**FREQUENCY INFORMATION**

How was this service previously reported? 88358 and 88342 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Pathology \_\_\_\_\_ Commonly x Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology \_\_\_\_\_ Frequency 2000 frequency for 88358 was 35,753. However, frequency is expected to decrease with revisions to code. Survey respondents indicated frequency between 5 and 1500 in the past year.

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty Pathology \_\_\_\_\_ Fequency Not known \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Do many physicians perform this service across the United States? \_\_\_\_\_ Yes x No \_\_\_\_\_

---

**AMA/Specialty Society Update Process**  
**PEAC Summary of Recommendation**  
**Pathology Codes**  
**Direct Inputs**

CPT Long Descriptor: Morphometric analysis; tumor (e.g., DNA ploidy)

Sample Size: No survey                      Response Rate: (%): \_\_\_\_\_  
 Global Period: \_\_\_\_\_

Tracking Number: \_\_\_\_\_ Reference Code 1 \_\_\_\_\_ Reference Code 2 \_\_\_\_\_

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %:     \_\_\_\_\_ Solo Practice  
                                   \_\_\_\_\_ Single Specialty Group  
                                   \_\_\_\_\_ Multispecialty Group  
                                   \_\_\_\_\_ Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: **The data were developed by a 12-member CAP committee with representation of the American Society of Cytopathology. The inputs were then reviewed by another group of 10 pathologists.**

Typical Patient Vignette: **A 54 year old female has previously been diagnosed with ductal carcinoma of the breast with axillary nodal metastasis identified on sentinel lymph node biopsy. The stained slides are analyzed by the pathologist, along with reference positive and negative samples, to determine if the staining process is interpretable and therefore warrants a semiquantitative or quantitative analysis. The stained slides are interpretable and the DNA ploidy evaluation is therefore performed. A semiquantitative or quantitative interpretation is provided using a computer assisted methodology.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: **The histotech retrieves the blocks and slides for review and selection of the appropriate block for slide preparation for morphometric analysis. 1 min.**

Intra-Service Clinical Labor Activities: **The histotech positions the block, cuts material for new slides, and prepares the new slides. 10 mins**

**Feulgen stain process: The histotech sorts and racks the new slides, hydrates them to distilled water, places the slides in 5N HCL, then places them in DNA staining solution, rinses them in 3 changes of rinse solution, washes them in distilled water, dehydrates the slides in 2 changes of reagent alcohol, clears them in 2 changes of xylene, and coverslips them. 15 min.**

**The histotech sorts and verifies the slides and delivers them to the pathologist. 4 min**

**The histotech prints out the information that arrived with the specimen, verifies the patient information and records it in the log book.**

Post-Service Clinical Labor Activities: The histotech prepares the slides and other material for storage. 3 min  
The histotech records the specimen data and backs it up. 1 min

## Total Staff Time:

HCFA's Staff Type Code**	Clinical Labor	Pre-Service Time	Service Period	Coordination of Care*	Post-Service Time	Cost Estimate and Source (if applicable)
1018	Lab Technologist	1 min			4 mins	
14017	Histotechnologist		29 mins			

\*By staff during the service period – Expense Incurred by Practice.

\*\* From HCFA's Labor, Medical Supply, and Equipment List for year 2002. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Cost Estimate and Source (if applicable)
	0.1N HCL DNA staining solution	0.2 ml	\$9.80/2.5L, Fischer
	5N HCL	0.2 ml	\$9.80/2.5L, Fischer
	0.05N HCL DNA rinse reagent	0.2 ml	\$9.80/2.5L, Fischer
	Acid alcohol	0.2 ml	\$9.80/2.5L, Fischer
	DNA stain kit	.10 kit	\$150/kit, Baxter
	DNA calibration slides	1 slide	\$31.25/box of 25 slides, Baxter
	Coverslip	3	Mercedes Coverglass, \$14.95, Baxter
11124	eye shield	1	
11303	gloves, disp, nitrile/chemo chemical	1 pair	
75016	Label	3	
75050	disposable microtome blades	1	
92007	microscope slide	2	
75084	hematoxylin stain	5 ml	
75117	positive control slide	1	

\* From HCFA's Labor, Medical Supply, and Equipment List for year 2002. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Procedure Specific Medical Equipment	Cost Estimate and Source (if applicable)
No code	Waterbath	
E13601	microscope, compound	

<b>E13618</b>	<b>Microtome</b>	
<b>E13642</b>	<b>robotic cover slipper</b>	
<b>E13644</b>	<b>slide dryer oven</b>	
<b>E13645</b>	<b>slide etcher</b>	
<b>E13646</b>	<b>solvent recycling system</b>	
<b>E91003</b>	<b>ventilator hood and blower</b>	
	<b>DNA image analyzer</b>	Chromavision ACIS, \$200,000, San Juan Capistrano, CA, 949-443-3355, 949-443-3310; chromavision.com.

\* From HCFA's Labor, Medical Supply, and Equipment List for year 2002. If not listed, please provide full description, estimated cost, and cost source.

As with the other pathology codes, 88358 should not be placed in the zero work pool.

**Type of Service: Pathology  
XXX Global Period**

**Clinical Services****Minutes****Staff Type – Circle****Pre-Service Period***Start: When containers/requisitions prepared for physician*

Prepare specimen containers/preload fixative/label containers/distribute requisition form(s) to physician \_\_\_\_\_ Histotech, Cytotech, Lab Tech, Other \_\_\_\_\_

Accession of specimen/prepare for examination \_\_\_\_\_ Histotech, Cytotech, Lab Tech, Other \_\_\_\_\_

Perform screening function (where applicable) \_\_\_\_\_

Other Clinical Activity (please specify) \_\_\_\_\_ 1 \_\_\_\_\_ Lab Technician

**Retrieve blocks and slides for review and select appropriate block for analysis**

*End: When specimen is ready for examination by pathologist.***Service Period***Start: When specimen is ready for examination by pathologist.*

Assist pathologist with gross specimen examination (including performance of intraoperative frozen sections) \_\_\_\_\_ Histotech, Cytotech, Lab Tech, Other \_\_\_\_\_

Prepare specimen for manual/automated processing \_\_\_\_\_ 10 \_\_\_\_\_ Histotech

Process specimen for slide preparation (includes processing, embedding, sectioning and recuts, centrifugation, routine and special staining, coverslipping, quality control function, maintaining specimen tracking, logs and labeling) \_\_\_\_\_ 15 \_\_\_\_\_ Histotech

Assemble and deliver slides with paperwork to pathologist \_\_\_\_\_ 4 \_\_\_\_\_ Histotech

Clean room/equipment while performing \_\_\_\_\_ Histotech, Cytotech, Lab Tech, Other \_\_\_\_\_

Coordinate Care \_\_\_\_\_ Histotech, Cytotech, Lab Tech, Other \_\_\_\_\_

Other Activity (please specify) \_\_\_\_\_ Histotech, Cytotech, Lab Tech, Other \_\_\_\_\_

*End: When specimen examination by pathologist is complete.***Post-Service Period***Start: When specimen examination by pathologist is complete.*

Prepare, pack and transport specimens and records for in-house storage and external storage (where applicable) \_\_\_\_\_ 3 \_\_\_\_\_ Lab Technician

Dispose of remaining specimens, spent chemicals/other consumable, and hazardous waste \_\_\_\_\_ Histotech, Cytotech, Lab Tech, Other \_\_\_\_\_

Clean room/equipment following procedure (including any equipment maintenance that must be done after the

procedure) \_\_\_\_\_ Histotech, Cytotech, Lab Tech, Other \_\_\_\_\_

Manage any relevant utilization review/quality assurance activities and regulatory compliance documentation \_\_\_\_\_ Histotech

Submit/receive material for consultation (where applicable) \_\_\_\_\_ 1 \_\_\_\_\_ Lab Technician

Other Activity (please specify) \_\_\_\_\_ Histotech, Cytotech, Lab Tech, Other \_\_\_\_\_

\_\_\_\_\_

*End: When specimen, chemical/waste and record handling is complete*

As with the other pathology codes, 88358 should not be placed in the zero work pool.

**AMA/Specialty Society Update Process**  
**PEAC Summary of Recommendation**  
**Pathology Codes**  
**Direct Inputs**

CPT Long Descriptor: Morphometric analysis; tumor immunohistochemistry (e.g., Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative.

Sample Size: No survey Response Rate: (%): \_\_\_\_\_

Global Period: \_\_\_\_\_

Tracking Number: \_\_\_\_\_ Reference Code 1 \_\_\_\_\_ Reference Code 2 \_\_\_\_\_

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
 \_\_\_\_\_ Single Specialty Group  
 \_\_\_\_\_ Multispecialty Group  
 \_\_\_\_\_ Medical School Faculty Practice Plan

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: **The data were developed by a 12-member CAP committee with representation of the American Society of Cytopathology. The inputs were then reviewed by another group of 10 pathologists.**

Typical Patient Vignette: **A 54 year old female has previously been diagnosed with ductal carcinoma of the breast with axillary nodal metastasis identified on sentinel lymph node biopsy. The stained slides are analyzed by the pathologist, along with reference positive and negative samples, to determine if the staining process is interpretable and therefore warrants a semiquantitative or quantitative interpretation. The immunoassay is positive and Her-2/neu evaluation is performed. A semiquantitative or quantitative interpretation is provided using a computer assisted methodology.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: **The histotech retrieves the blocks and slides for review and selection of the appropriate block for slide preparation for morphometric analysis.**

Intra-Service Clinical Labor Activities: **The histotech prints out the information that arrived with the specimen, verifies the patient information and records it in the log book. The histotechnologist chills the block(s), labels blank slides, cuts and deparaffinizes patient and control slides, and gathers, weighs, measures, mixes and prepares staining solutions. Slides are stained and counterstained in multiple steps. Slides are coverslipped, labels are generated and placed on slides, slides and controls are reviewed for staining adequacy, and the stain record is completed. The slides are then delivered to the pathologist.**

**The histotech sorts and verifies the slides and delivers them to the pathologist.**

Morphometric analysis is done after calibration of the equipment (pathologist activity).

**Post-Service Clinical Labor Activities:** The histotech prepares the slides and other material for storage. The histotech records the specimen data and backs it up.

Total Staff Time:

HCFA's Staff Type Code**	Clinical Labor	Pre-Service Time	Service Period	Coordination of Care*	Post-Service Time	Cost Estimate and Source (if applicable)
1018	Lab Technologist	2 min			20 min	
14017	Histotechnologist		52 mins			

\*By staff during the service period – Expense Incurred by Practice.

\*\* From HCFA's Labor, Medical Supply, and Equipment List for year 2002. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
92002	Coverslip	7		Mercedes Coverglass, \$14.95, Baxter
11124	eye shield	1		
11303	gloves, disp, nitrile/chemo chemical	1 pair		
75016	Label	7		
75050	Disposable microtome blades	2		
92007	Microscope slide	6		
75084	Hematoxylin stain	5 ml		
75117	positive control slide	2		
11304	Gown, staff, impervious, disposable	1		
75050	Microtome blades, disposable	2		
75089	Mounting media	2 ml		
New	Peroxide block	50 ml	1000 ml	Cell Marque CMX103, \$49 (Cell Marque: 1-800-665-7284)
New	Tissue revival	50 ml	1000 ml	Cell Marque CMX602, \$74
New	Background block	5 ml	200 ml	Cell Marque CMX200, \$49
New	Antibody	.12 ml	6 ml	Cell Marque CMA710, \$189
New	Biotinylated link	.4 ml	50 ml	Cell Marque CMD102, \$199
New	Streptavidin label	.4 ml	50 ml	Cell Marque CMD202, \$199
New	AEC Chromogen	.12 ml	3 ml	Cell Marque CMD410, \$49
New	AEC buffer	2 ml	50 ml	Cell Marque CMD420, \$20
New	Hematoxylin	8 ml	200 ml	Cell Marque CMD401, \$59
New	Buffer	1 packet	10 packets	Zeus 0008, \$31 (Zeus: 1-800-257-9525)

\* From HCFA's Labor, Medical Supply, and Equipment List for year 2002. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Procedure Specific Medical Equipment	Cost Estimate and Source (if applicable)
<b>E13601</b>	<b>Microscope, compound</b>	
<b>E13618</b>	<b>Microtome</b>	
<b>E13642</b>	<b>Robotic cover slipper</b>	
<b>E13644</b>	<b>slide dryer oven</b>	
<b>E13645</b>	<b>slide etcher</b>	
<b>E13646</b>	<b>Solvent recycling system</b>	
<b>E91003</b>	<b>Ventilator hood and blower</b>	
	<b>DNA image analyzer</b>	Chromavision ACIS, \$200,000, San Juan Capistrano, CA, 949-443-3355, 949-443-3310; chromavision.com.
<b>New</b>	<b>Waterbath (\$760, Precision General Purpose Waterbath #B7009-4, Allegiance)</b>	
	<b>Decloaking Chamber (Next Generation Decloaking Chamber DC2001, \$875, Biocare Medical, 800-799-9499)</b>	

\* From HCFA's Labor, Medical Supply, and Equipment List for year 2002. If not listed, please provide full description, estimated cost, and cost source.

**Type of Service: Pathology  
XXX Global Period**

<u>Clinical Services</u>	<u>Minutes</u>	<u>Staff Type – Circle</u>
<b>Pre-Service Period</b>		
<i>Start: When containers/requisitions prepared for physician.</i>		
Prepare specimen containers/preload fixative/label containers/distribute requisition form(s) to physician	_____	Histotech, Cytotech, Lab Tech, Other _____
Accession of specimen/prepare for examination	_____	
Perform screening function (where applicable)	<u>  2  </u>	Lab Technologist
Other Clinical Activity (please specify)		
<b><u>Retrieve blocks and slides for review and select appropriate block for analysis</u></b>		
_____		
<i>End: When specimen is ready for examination by pathologist.</i>		
<b>Service Period</b>		
<i>Start: When specimen is ready for examination by pathologist.</i>		
Assist pathologist with gross specimen examination (including performance of intraoperative frozen sections)	_____	Histotech, Cytotech, Lab Tech, Other _____
Prepare specimen for manual/automated processing	<u>  18  </u>	Histotech
Process specimen for slide preparation (includes processing, embedding, sectioning and recuts, centrifugation, routine and special staining, coverslipping, quality control function, maintaining specimen tracking, logs and labeling)	<u>  32  </u>	Histotech
Assemble and deliver slides with paperwork to pathologist	<u>  2  </u>	Histotech
Clean room/equipment while performing	_____	Histotech, Cytotech, Lab Tech, Other _____
Coordinate Care	_____	Histotech, Cytotech, Lab Tech, Other _____
Other Activity (please specify)	_____	Histotech, Cytotech, Lab Tech, Other _____
_____		
<i>End: When specimen examination by pathologist is complete.</i>		
<b>Post-Service Period</b>		
<i>Start: When specimen examination by pathologist is complete.</i>		
Prepare, pack and transport specimens and records for in-house storage and external storage (where applicable)	<u>  12  </u>	Lab Technician
Dispose of remaining specimens, spent chemicals/other consumable, and hazardous waste	<u>  5  </u>	Lab Technician

- Clean room/equipment following procedure (including any  
- equipment maintenance that must be done after the  
- procedure) \_\_\_\_\_  
\_\_\_\_\_

Manage any relevant utilization review/quality assurance  
activities and regulatory compliance documentation \_\_\_\_\_  
\_\_\_\_\_ 3 \_\_\_\_\_

Submit/receive material for consultation (where applicable) \_\_\_\_\_  
\_\_\_\_\_

Lab Technician

Other Activity (please specify)

\_\_\_\_\_  
*End: When specimen, chemical/waste and record handling is  
complete.*

As with the other pathology codes, 88361 should not be placed in the zero work pool.

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Capsule Tract Imaging**

The CPT Editorial Panel created a new CPT code 91110 *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* to describe this new approach to examine the gastrointestinal tract. In 2002, CMS had created Code G0262 *Small intestinal imaging; intraluminal, from ligament of Treitz to the ileo cecal valve, includes physician interpretation and report* (work rvu = 2.12) to report this new technology until CPT created a new code for *CPT 2004*.

In developing interim work relative values for code G0262, CMS relied on a comparison to the intra-service work per unit of time (IWPUT) derived by reviewing the work values and intra-service time for several services, including electroencephalography (EEG) reading and interpretation, magnetic resonance angiography (MRA), computed tomographic angiography (CTA), Holter monitoring reading and interpretation, prolonged esophageal acid reflux testing, echocardiography, duplex scanning of the carotid arteries, and anorectal manometry. Based on these comparisons, CMS determined that the average intensity measure of 0.04 should be applied to an intra-service time of 53 minutes, which they obtained from literature available in December 2002.

Gastroenterology subsequently conducted a survey of nearly 30 physicians who had experience in performing this service. The survey median work relative value was 5.80, with an intra-service time of 120 minutes. The specialty society chose to recommend the 25% work rvu of 5.00 to the RUC. The RUC, however, noted specific flaws in the survey instrument that may have led survey respondents to either misclassify post-operative work into the intra-service period and/or allocate physician time to certain clinical staff tasks. The RUC acknowledged that based on the analysis already completed by CMS, that the intra-service time for this service is critical to the appropriate valuation.

The RUC reviewed a recently published journal article published in the *European Journal of Gastroenterology and Hepatology* and agreed that the article's estimation of 80 minutes of intra-service time was reasonable. The RUC noted that the removal of the report writing time from the surveyed time and the time associated with services that are performed by clinical staff approximates 80 minutes.

The committee also extensively discussed the pre and intra service time associated with this service and compared this service to other diagnostic tests with a XXX global period. The committee recommends that a small amount of pre-service time (5 minutes) and 15 minutes of post-service time for report writing and other post-service activities are appropriate. The RUC recommends the following revised physician time: **Pre-Service Time: 5 minutes; Intra-Service time: 80 minutes; Post-Service Time: 15 minutes**

The RUC noted that it was very difficult to find a comparable reference service to link this new code to and offered that computing a value utilizing IWP/UT offers the best alternative for this service. The facilitation committee agreed with the CMS analysis of similar codes with similar IWP/UT as published in the *Federal Register* (0.04).

80 minutes intra-time x .040 intensity = 3.20 intra-work related to reading time  
 20 minutes of pre and post work x .0224 = 45  
 3.20 + 0.45 = 3.65

**The RUC recommends a work relative value of 3.65 for 91110.**

The RUC understands that a separate Evaluation and Management service may be reported on the same day as this service if a separately identifiable service is performed.

Practice Expense

The facilitation committee extensively reviewed the direct practice expense inputs and made several revisions, including significant reductions in the pre-service and service clinical staff times. A revised spreadsheet is attached to the recommendations

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
91110	MM1	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report  (Visualization of the colon is not reported separately)  (Append modifier ‘-52’ if the ileum is not visualized)	XXX	3.65

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

---

CPT Code: 91110    Tracking Number: MM1    Global Period: XXX    Recommended RVW: 5.0  
RUC Rec: **3.65**

**CPT Descriptor:** Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** A 57-year old man has a history of obscure gastrointestinal bleeding. He is referred for wireless capsule endoscopy. After a 12 hour fast, the patient presents for capsule endoscopy. After informed consent is obtained, the patient's abdomen is cleaned and shaved for proper placement of the sensor array. The belt assembly, including the data recorder and battery pack, is adjusted to fit the patient and attached to the sensor array. The battery pack has been completely charged the previous evening. The patient is instructed on the ingestion technique and swallows the capsule endoscope. The patient is observed for immediate signs of complications; if none are observed the patient is discharged. The patient is instructed not to resume eating for 4 hours. The capsule advances by peristalsis through the GI tract. After 8 hours the patient returns and is assessed for signs or symptoms of complications. The data recorder belt and sensor array are removed and disinfected. The physician discusses relevant procedural feedback with the patient. The patient is discharged. Numerous video images and diagnostic information from the data recorder are downloaded to the workstation for processing. Once the download information is complete, the physician reviews the capsule images at 15 frames/second base rate with frequent stops to evaluate potential diagnostic abnormalities. During the review, the physician activates the localization software to input the esophagogastric junction, pylorus and ileocecal valve locations. After completing the analysis of the images and diagnostic information, the physician makes a diagnosis and generates a report.

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

**Description of Pre-Service Work:**

Assess for possible contraindications such as presence of pacemaker, active bowel obstruction or swallowing disorder. Provide education to patient on the nature of the procedure, why it is being performed and possible complications. Provide instructions to patient on preparation for the procedure—fasting, clothing to wear, etc. Obtain informed consent.

**Description of Intra-Service Work:**

Staff performs all needed functions for procedure including obtaining and entering needed data into recorder, placing sensor array on abdomen, and attaching battery pack to recorder. Patient is given capsule to swallow, which is observed by physician, and patient is provided instructions for activities, meals and return time. Patient returns after 8-9 hours where sensor array is removed and data downloaded from recorder to work station by staff. Physician then proceeds to review 50,000-60,000 images.

- Entire study scanned and key anatomic landmarks annotated (e.g., esophagogastric junction, duodenum, ileocecal valve) permitting identification of potentially positive findings and determination of gastric and small bowel emptying times.
- Once the landmarks (“thumbnails”) have been determined, all the images are viewed. When an abnormality is identified, a “thumbnail” is created. Key findings or abnormalities are noted and recorded on a localization drawing that may also be used to guide subsequent surgery.

**Description of Post-Service Work:**

Upon completion of review of all images and formulating and interpretation, a report is prepared and dictated.

The findings are communicated to the patient and a copy of the report is sent to the referring physician. The referring physician may also be contacted to discuss the findings.

---

**SURVEY DATA**

<b>Presenter(s):</b>	Maurtis Wiersema, MD Joel Brill, MD					
<b>Specialty(s):</b>	American Society of Gastrointestinal Endoscopy American Gastroenterological Association					
<b>CPT Code:</b>	91110					
<b>Sample Size:</b>	60	<b>Resp n:</b>	29	<b>Resp %:</b>	48%	
<b>Sample Type:</b> Panel Sample						
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>		2	5	5.8	7	21.04
<b>Pre-Service Evaluation Time:</b>		0	15	20.5	40	90
<b>Pre-Service Positioning Time:</b>						
<b>Pre-Service Scrub, Dress, Wait Time:</b>						
<b>Intra-Service Time:</b>		60	105	120-80	150	300
<b>Immed. Post-time:</b>		5	15	15	30	60
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>				
<b>Critical Care time/visit(s):</b>						
<b>Other Hospital time/visit(s):</b>						
<b>Discharge Day Mgmt:</b>						
<b>Office time/visit(s):</b>						

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
44376	Small intestine endoscopy, enteroscopy beyond second portion of duodenum, including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing	7.85	5.26

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

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

Number of respondents who choose Key Reference Code: 25

**TIME ESTIMATES (Median)**

New/Revis.  
CPT Code: 91110  
Key Reference  
CPT Code: 44376

Median Pre-Service Time	20.5	30
Median Intra-Service Time	120.80	180
Median Immediate Post-service Time	15	17
Median Critical Care Time		
Median Other Hospital Visit Time		
Median Discharge Day Management Time		
Median Office Visit Time		
Median Total Time	155.100	227

**INTENSITY/COMPLEXITY MEASURES (Mean)\***

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.44	4.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.56	3.96
Urgency of medical decision making	3.56	3.84

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.92	4.24
Physical effort required	3.21	3.92

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.92	3.80
---	------	------

\*The Intensity/Complexity Measures sections contains only those respondents who chose code 44376 as the reference code.

Outcome depends on the skill and judgement of physician	4.25	4.12
---	------	------

Estimated risk of malpractice suit with poor outcome	3.79	3.92
--	------	------

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference**  
**Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.08	2.96
----------------------------------	------	------

Intra-Service intensity/complexity	4.56	4.08
------------------------------------	------	------

Post-Service intensity/complexity	3.48	2.92
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

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

Capsule endoscopy is a very atypical procedure for Gastroenterologists to evaluate through the usual RUC survey process. Virtually all procedures performed by gastroenterologists are endoscopic procedures, which are invasive in nature. In contrast, capsule endoscopy is an imaging procedure but one which is extremely time consuming and very intense. The intensity derives from the fact that only 2 or 3 images out of some 50,000 images are frequently the key to finding the source of obscure bleeding or other pathology. We had a difficult time determining appropriate reference codes for this service and developed a listing including certain imaging codes, E/M codes and a few endoscopy codes. The list was shared with RUC staff in advance. While the majority of the respondents identified code 44376 as the reference code, since that is the endoscopic procedure that historically was used for similar diagnostic problems, we frankly think it is probably not a very good comparison code. First, the service is rarely performed--much less than 1,000 times annually in the Medicare population. Second, the RUC time data for the reference code seems erroneous on its face with 180 minutes of intra time. Either the time data is grossly inaccurate for code 44376 or the work value of 5.26 RVUs is grossly inadequate. If this time were right and this procedure were valued with an IWPUT consistent with other codes in that family, it would suggest that the work value of that code is probably undervalued by a factor of 50%. We think the problem is with the time data.

We carefully evaluated the survey data and concluded that the median work value recommended might be excessive. We think the work value recommended at the 25th percentile of 5.0 RVUs is more appropriate. Using an RVU of 5.0 and the median time data would result in an IWPUT of 0.035 assigning a work value of 0.0224 to be the pre and post time. Using the 25<sup>th</sup> percentile of time data and an RVU of 5.0, the IWPUT would be 0.041. Considering the IWPUT for other diagnostic services, we think this would be a very reasonable IWPUT level. For example, code 95951, EEG with video monitoring, also involves a lengthy interpretation and has an IWPUT of 0.06. Code 74181 is an MRI of the abdomen and has an IWPUT of 0.048. And code 73654 is an X-ray of the knee and has an IWPUT of 0.048. We would also note that the time at the intra 25th percentile of 105 minutes is more consistent with data in some of the research studies. We found 12 studies that were published that have time references and the median "read time" was approximately 90 minutes. However, this time does not include the time for preparing the report. In addition, as with the study cited by CMS in the December 31, 2002 final rule used in the evaluation of G0262, we confirmed that some of the researchers did not factor in all the preparatory time (e.g., in identifying key anatomic landmarks AKA "thumbnails") in estimating reading time. Thus, we think an intra time of 105 minutes is clearly justified

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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



---

**FREQUENCY INFORMATION**

How was this service previously reported? 44376-22 or 44799 or 91299 with 99070 or A4649 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Gastroenterologists \_\_\_\_\_  Commonly  Sometimes  Rarely

Specialty \_\_\_\_\_  Commonly  Sometimes  Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterologists \_\_\_\_\_ Frequency ≈25,000 \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty Gastroenterologists \_\_\_\_\_ Frequency ≈10,000 \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

---

**AMA/Specialty Society Update Process  
RUC Summary of Recommendation  
XXXGlobal Period  
In Office Direct Inputs**

Sample Size: 60      Response Rate: (%): 48%      Global Period: XXX

Tracking Number: MMI      Reference Code 1 44376      Reference Code 2 99245

Geographic Practice Setting %: Rural 10%      Suburban 24%      Urban 66%

Type of Practice %:    21% Solo Practice  
                              45% Single Specialty Group  
                              21% Multispecialty Group  
                              14% Medical School Faculty Practice Plan

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

Representatives of the American Gastroenterological Association and the American Society for Gastrointestinal Endoscopy had several meetings to discuss the practice expense inputs for Code 911XX, Gastrointestinal Tract Imaging. Information was obtained from physician practices familiar with this procedure on the staff time, supplies and equipment used to perform this service. In addition, physicians who have done some of the clinical research were also contacted. Agreement was reached on the typical inputs for the procedure in both a facility and non-facility setting

**Please describe the clinical activities of your staff:**

*Pre-Service Clinical Labor Activities:* Patient is given instructions regarding fasting, clothing to wear, and general education on procedure.

*Intra-Service Clinical Labor Activities:* Prior to the patient's arrival, the equipment will be calibrated and the work station initialized for the specific patient. When the patient arrives, the patient is greeted, vital signs are taken, male patients need to have their chests shaved to assure that the sensors make good contact. The patient is given instructions on the procedure, restrictions on activities and a diary to maintain until their return approximately 8 hours later. The patient is hooked up with the recording belt and sensor array and is then given the capsule camera to swallow. After observing the patient for a few minutes, the patient departs. Upon their return, patients have the equipment disconnected, and given home care instructions such as when the camera is likely to be eliminated, problems to be alert to, etc. After the patient leaves, the equipment is disinfected, the data is downloaded into the system and batteries are recharged

CPT Code: 91110

Specialty Society('s) ASGE/AGA

HCFA's Staff Type Code*	Clinical Labor – Description	Pre-Service Time – Minutes	Service Period (Day of service)	Cost Estimate and Source (if applicable)
1130	RN/LPN/MTA	5	68	

\* From HCFA's Labor, Medical Supply, and Equipment List. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies - Description	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
See spreadsheet				

\* From HCFA's Labor, Medical Supply, and Equipment List. If not listed, please provide full description, estimated cost, and cost source.

HCFA Equipment Code*	Medical Equipment – Description	Cost Estimate and Source (if applicable)
	See spreadsheet	

\* From HCFA's Labor, Medical Supply, and Equipment List. If not listed, please provide full description, estimated cost, and cost source.

**AMA/Specialty Society Update Process  
RUC Summary of Recommendation  
XXX Global Period  
Out-Of-Office Direct Inputs**

Sample Size: 60      Response Rate: (%): 48%      Global Period: XXX

Tracking Number: MMI      Reference Code 1 44376      Reference Code 2 99245

Geographic Practice Setting %: Rural 10%      Suburban 24%      Urban 66%

Type of Practice %:    21% Solo Practice  
                                  45% Single Specialty Group  
                                  21% Multispecialty Group  
                                  14% Medical School Faculty Practice Plan

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

Representatives of the American Gastroenterological Association and the American Society for Gastrointestinal Endoscopy had several meetings to discuss the practice expense inputs for Code 91110, Gastrointestinal Tract Imaging. Data was obtained from physician practices familiar with the performance of the procedure in both a hospital and office setting to identify the typical staff time, supplies and equipment used to perform this service. Please describe the clinical activities of your staff:

**Pre-Service Clinical Labor Activities:** See spreadsheet attached.

**Intra-Service Clinical Labor Activities:**

HCFA's Staff Type Code**	Clinical Labor	Pre-Service Time	Service Period	Coordination of Care*	Cost Estimate and Source (if applicable)
1130	RN/LPN/MTA			3	

\*By staff in the physician's office during the service period.

\*\*From HCFA's Labor, Medical Supply, and Equipment List. If not listed, please provide full description, estimated cost, and cost source.

ICFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)

\*From HCFA's Labor, Medical Supply, and Equipment List. If not listed, please provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	Cost Estimate and Source (if applicable)

\*From HCFA's Labor, Medical Supply, and Equipment List. If not listed, please provide full description, estimated cost, and cost source

## Wireless capsule video endoscopy is a superior diagnostic tool in comparison to barium follow-through and computerized tomography in patients with suspected Crohn's disease

Rami Eliakim<sup>a</sup>, Doron Fischer<sup>b</sup>, Alain Suissa<sup>a</sup>, Kamal Yassin<sup>a</sup>, Dalia Katz<sup>a</sup>, Nurit Guttman<sup>c</sup> and Michal Migdal<sup>c</sup>

**Background** The recently introduced wireless M2A capsule video endoscopy (CVE) has been demonstrated to be superior to barium follow-through and enteroscopy in diagnosing patients with occult blood loss and iron-deficiency anaemia.

**Objective** To further investigate CVE in comparison to barium follow-through and entero-computerized tomography (CT) in establishing the diagnosis of patients with suspected Crohn's disease.

**Design and setting** The study was conducted in one academic hospital. Twenty patients with recurrent abdominal pain and/or weight loss or chronic diarrhoea underwent barium follow-through as their initial examination, followed by CVE (if there was no stricture) and entero-CT. The radiologist that performed the barium follow-through and entero-CT was blinded to the results of the CVE. A blinded reader who was unaware of the study objective diagnosed the results of the CVE. In most cases in which there was a discrepancy between examinations, colonoscopy and ileoscopy were performed. For each patient, the diagnosis and disease extent were recorded.

**Results** Twenty patients (13 males, 7 females; mean age 31 years, range 20–57) were included in the study. Ninety-five per cent of the patients had abdominal pain, 75% had diarrhoea, and 65% had weight loss. The mean haemoglobin level of the group was 13.1 g% (range 10–15.5). Only 13 patients underwent entero-CT.

**CVE confirmed the diagnosis of Crohn's disease that was suspected by alternative methods in six of the 20 patients. CVE made the diagnosis of Crohn's disease in six patients that had normal barium follow-through or entero-CT. CVE**

**ruled out a diagnosis of Crohn's disease suspected by other modalities in three patients. CVE extended the involvement of Crohn's disease in three of the patients, and established new diagnoses in two patients.**

**Summary** CVE established new diagnoses, confirmed existing diagnoses, enlarged the extent of the disease, and ruled out the suspicion of Crohn's disease in 70% of the patients. Barium follow-through established diagnoses, measured the extent of the disease, and ruled out the suspicion of Crohn's disease in 37% of the patients.

**The capsule detected all of the lesions diagnosed by barium follow-through and entero-CT. CVE detected additional lesions that were not detected by other modalities in 47% of cases and ruled out lesions that were detected by other modalities in 16% of cases ( $P < 0.05$ ).**

**Conclusion** CVE is a superior and more sensitive procedure than barium follow-through and entero-CT in establishing the diagnosis and estimating the extent of Crohn's disease. *Eur J Gastroenterol Hepatol* 15:363–367 © 2003 Lippincott Williams & Wilkins

*European Journal of Gastroenterology & Hepatology* 2003, 15:363–367

**Keywords:** capsule endoscopy, CT, small-bowel follow-through, Crohn's disease

Departments of <sup>a</sup>Gastroenterology and <sup>b</sup>Radiology, Rambam Medical Centre, Technion School of Medicine, Haifa, and <sup>c</sup>Given Imaging, Yoqneam, Israel.

Correspondence to R. Eliakim MD, Department of Gastroenterology, Rambam Medical Centre, Bat Galim, Haifa, P.O.B. 9602, Israel 31096. Tel: +072 4 854 2604; fax: +072 4 854 3058; e-mail: r\_eliakim@rambam.health.gov.il

Received 7 August 2002 Revised 10 October 2002 Accepted 6 November 2002

### Introduction

Diagnosing early Crohn's disease can be difficult, as barium small-bowel series, the most commonly used procedure, may produce a negative result. The terminal ileum is otherwise accessible only via conventional colonoscopy, and this has shown to be unsuccessful on numerous occasions. The yield of barium small-bowel

follow-through to demonstrate the extent and severity of Crohn's disease of the small bowel has been reported from a significantly low result [1–3] to a very good result with a sensitivity of 90% and a specificity of 96% [4,5]. Computerized tomography (CT) is a diagnostic tool superior to barium studies as it has the ability to observe directly the small-bowel wall, adjacent abdom-

Capsule endoscopy in Crohn's disease Eliakim et al. 365

inflammatory drugs (NSAIDs), 5-aminosalicylic acid (5-ASA) or steroids for their gastro complaints in the past. There was no evidence of gastrointestinal bleeding in any of the patients. The mean duration of symptoms before enrolment was 8 months (range 2-15). The patients underwent 48 procedures before entry to the present trial (Table 1). Previous procedures included 23 colonoscopies, 11 gastroscopies, ten barium follow-throughs and three CT scans. Nineteen of the patients had at least one procedure, none of which explained the patients' symptoms. All of the original 20 patients swallowed the capsule, i.e. the small-bowel follow-through did not exclude any patient due to a stricture. The ingestion went smoothly in all patients, and there were no side effects during or after the procedure. Mean gastric emptying time of the capsule was 1 h 8 min (range 12 min to 3 h, standard deviation [SD]

1 h). Mean small-bowel emptying time was 4 h 3 min (range 2-5 h, SD 57 min). Preparations for the capsule procedure took 20 min, hook-up took 5 min, and review of each film took 80 min. Capsule findings were identified as 'medically significant or explained the patient's reason for referral' in 14 of the 20 patients; therefore, the diagnostic yield of the capsule was calculated as 70% (14/20). Capsule findings included ulcers and erosions (36%), erythema (22%), aphthae (17%), absent or blunted villi (14%), and nodular lymphoid hyperplasia (5.6%) (Table 2). The comparative procedures (small-bowel follow-through, entero-CT) found abnormalities in 50% of cases. The abnormalities included wall thickening (23%), nodularity in terminal ileum (17%), and ulcers (5.6%). Radiographic abnormalities were medically significant in regard to the patient's complaints in only seven patients (Table 2). These abnormalities included nodularity of the terminal ileum, thickening of the terminal ileum/caecum/valve/wall (22%), increased/enlarged mesenteric nodes (11%), and other findings suggestive of terminal ileitis (33%). Thus, the diagnostic yield of radiological procedures was 35%. Using McNemer's test to compare the diagnostic yield of the procedures, the capsule was found to be more significant (70% v. 35%,  $P < 0.0391$ ). Colonoscopy and ileoscopy with biopsies confirmed the capsule's findings in eight patients in which there were controversial results between procedures. In every patient, the capsule found all the abnormalities that were found in radiology. The capsule confirmed radiological

Table 1 Distribution of procedures that patients underwent before enrolment in the study

	Patients (n)	Procedures (n)	Average procedures/patient (n)
Gastroscopy	11	11	1.00
Colonoscopy	17	23	1.35
Small-bowel follow-through	8	10	1.25
Plain abdominal	1	1	1.00
Computed tomography	2	3	1.50
Total	20	48	2.40

Table 2 Type and distribution of significant lesions found by M2A capsule video endoscopy (CVE), barium follow-through and entero-computerized tomography (ECT) in 20 patients suspected to have Crohn's disease

Patient	M2A	ECT/small-bowel follow-through
CAN08	Duodenum: erosions, erythema. Terminal ileum: ulcer, erosions, erythema	Ileum: nodularity, suspected terminal ileitis
YUN04	Small bowel: ulcer, erosions, erythema	Irregular terminal ileum
SMY06	Terminal ileum: ulcer, erosions, erythema. Small bowel: ulcer	Suspected Crohn's disease/terminal ileitis (thickening of bowel wall and ulcerations)
SGO08	Normal	Normal
YSH07	Terminal ileum: nodular lymphoid hyperplasia (confirmed by ileoscopy)	Thickening of terminal ileum wall and nodularity
MGO08	Terminal ileum: nodular lymphoid hyperplasia (confirmed by ileoscopy)	Thickening of terminal ileum wall and nodularity
SSH09	Duodenum: erythema. Small bowel: areas with erythema/aphthae	Thickened valve: suspected Crohn's disease
AMI10	Small bowel: several aphthae. Duodenum: aphthae. Terminal ileum: aphthae	Thickening of terminal ileum wall and caecal wall, enlarged mesenteric nodes
CCO11	Terminal ileum: ulcer. Small bowel: ulcer, aphthae in several parts of the intestine	Normal
MAK12	Normal	Normal
ZST13	Terminal ileum: ulcer, oedema, erythema. Small bowel: erythema, blunted villi (confirmed by ileoscopy)	Normal
INS14	Normal (confirmed by ileoscopy)	Irregular terminal ileum
RNA15	Terminal ileum: ulcer, erythema (confirmed by ileoscopy)	Normal
YBA16	Normal	Normal
SYE17	Small bowel: blunted/absent villi (confirmed by enteroscopy)	Enlarged jejunal loops with flocculation
RMO18	Normal	Normal
ADA19	Small bowel: erythema, absent villi	Normal
RDO20	Normal	Normal
SGO21	Terminal ileum: aphthae. Small bowel: linear ulcer, erosions, erythema (confirmed by ileoscopy)	Normal
RTA22	Small bowel: erosions, blunted villi	Normal

inal organs, mesentery and retroperitoneum, enabling the diagnosis of the most severe complications of Crohn's disease [6]. The role of CT in diagnosing early Crohn's disease remains to be determined.

The small bowel is the most difficult section of the gastrointestinal tract to examine endoscopically because of its length, its free peritoneal location constrained by mesenteric attachments, and multiple complex looped configurations.

Recently, a wireless capsule endoscope was developed that is now available for clinical practice [7]. The capsule has demonstrated superiority to push enteroscopy in detecting small-bowel abnormalities in an animal model [8] and in patients with suspected small-bowel bleeding [9,10].

The present study compares capsule endoscopy with small-bowel follow-through and entero-CT as diagnostic tools in patients with suspected Crohn's disease.

### Subjects and methods

Twenty consecutive patients with recurrent abdominal pain and/or chronic diarrhoea with or without weight loss were enrolled in the study. Each patient was referred either by their family practitioner or by a gastroenterologist. Patients with a prior history of bowel obstruction, major abdominal surgery, diabetes mellitus, cardiac pacemaker, or any mental condition that precludes compliance were excluded from the study. Pregnant women were also excluded. All patients signed a written informed consent form, and the local Helsinki committee approved the study. The patients' demographic data (age, gender, weight, height, waist-line), nutritional status, and alcohol and substance abuse history were recorded. Gastrointestinal related medical history (abdominal pain, diarrhoea, malnutrition data, bleeding) and results of previous diagnostic procedures (gastroscopy, biopsy, colonoscopy, barium follow-through, CT, enteroscopy) were recorded along with current diseases and risk factors. A physical examination was performed and results were recorded. Recent laboratory data (haemoglobin, haematocrit, platelets, white blood cell count, ferritin) and past or current medications were also recorded.

Patients underwent a barium follow-through. If there was no contraindication (i.e. stricture), they swallowed the capsule and an entero-CT was performed. All three procedures were completed within 3 months of each other. An experienced gastrointestinal radiologist, who was blinded to the results of the capsule procedure, interpreted the barium follow-through and CT. The gastroenterologist reading the capsule video films was blinded to the radiology findings. Given Imaging Ltd assigned another blinded gastroenterologist, who was

totally unaware of any previous results, to read the capsule films. In most cases in which there was discrepancy between examinations (capsule endoscopy, entero-CT, barium follow-through), colonoscopy and ileoscopy were performed. The diagnosis and disease extent were recorded in all patients.

### Capsule endoscopy procedure

Patients were examined after a 10-h overnight fast. They were connected to the recording device, after which they swallowed the capsule. Patients were required to remain in the clinic for 1 h to verify that the capsule transmission was adequate. They were then permitted to drink clear liquids and were free to continue with their daily activities. Four hours after ingesting the capsule, patients were allowed to eat a light lunch. They returned for removal of the recorder after 7 h. The fasting period, ease of ingestion, time of drinking and eating, time of discharge, and any signs, symptoms or discomfort that occurred during the procedure were recorded. The entrance times of the capsule to the stomach, duodenum, small bowel and caecum were recorded, and gastric and small-bowel emptying times were calculated. Abnormal findings and their locations were also recorded. Patients were contacted by telephone a few days later to enquire as to whether they had any unusual symptoms and whether the capsule had exited. The patients completed a subjective questionnaire comparing the capsule procedure with other comparative procedures, and the physician completed a questionnaire regarding the time spent on preparation, hook-up, downloading and reviewing the capsule procedure.

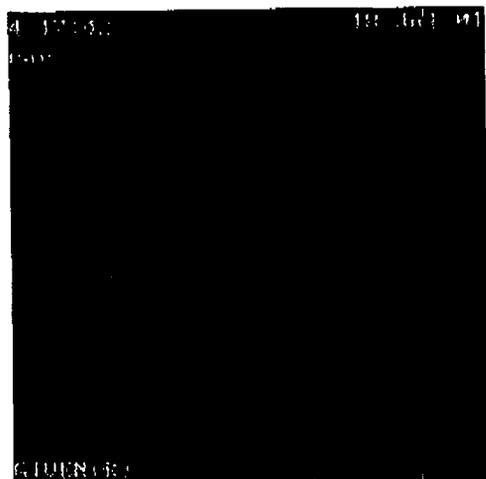
### Entero-CT procedure

This was performed as a normal abdominal scan with the patient in the supine position after a continuous ingestion of 1500 ml of diluted water-soluble contrast material (30% Telebrix). Opacification of the bowel continued until the scan was performed. One hundred millilitres of contrast material were injected (2 ml/s), and scanning began 60 s later. The scanning started at the base of the lungs and ended at the groin, all in one held breath. The collimation was 10 mm, and the section width was 2.5 mm. Multiplan reconstructions were performed routinely at the end of the examination in both coronal and sagittal planes, on a workstation (Omnipo 3, Algotec).

### Results

Twenty consecutive patients (13 males, 7 females) completed the study. The mean age was 30.8 years (range 20–57). The mean weight was 63 kg (range 48–98). Ninety-five per cent of the patients had abdominal pain, 75% had diarrhoea, and 65% had weight loss (significant in 45%). None of the patients was on medication, nor had they taken nonsteroidal anti-

Fig. 1



Endoscopic (M2A) image from the terminal ileum of a patient showing two ulcers and erythema, compatible with Crohn's disease of the terminal ileum.

Fig. 2



Endoscopic (M2A) image from the terminal ileum of a patient showing small nodules in the terminal ileum, compatible with nodular lymphoid hyperplasia.

findings in six patients, extended involvement in three patients (Fig. 1), and ruled out the radiological suspicion of Crohn's disease in three patients (Fig. 2) (all of which were confirmed by ileoscopy and biopsies). There was full agreement between the two M2A capsule results' readers in 80% of cases. Disagreement was found in two patients with nodular lymphoid

hyperplasia in the terminal ileum, which was read as normal by one viewer and in two patients with lesions in the terminal ileum. In three of these four patients, ileoscopy with biopsies was performed and confirmed the diagnosis. The patients diagnosed as Crohn's patients were treated with either 5-ASA or corticosteroids, with significant clinical improvement over time.

### Discussion

The diagnostic yield of barium small-bowel follow-through when used to demonstrate the extent and severity of Crohn's disease of the small bowel varies from low to very good in various publications [1-5]. The authors of the National Cooperative Crohn's Disease Study concluded that the barium follow-through of the small intestine failed to demonstrate the extent and severity of Crohn's disease in a significant number of patients [1]. The study was conducted at 14 university hospital centres, reflecting the average level of radiographic expertise with barium follow-through. Other authors have reported a sensitivity of 90% and a specificity of 96% [4,5]. These results are similar to those reported by enteroclysis (98% and 93%, respectively) [11]. In the present study, wireless capsule endoscopy was shown to be a superior diagnostic tool in comparison to conventional radiological methods in establishing the diagnosis in patients suspected to have Crohn's disease of the small bowel. The capsule identified all true lesions found by radiology, extended the regions of involvement in some patients, made a diagnosis in one-third of the patients when radiology was interpreted as normal, and ruled out the diagnosis suspected by radiology in some patients. The capsule's macroscopic findings were confirmed in most cases by ileoscopic biopsies, by the fact that no patients took NSAIDs, and by the good response to specific therapy.

One of our major concerns was that, due to the natural history of the disease, the capsule might encounter a narrowed diseased segment of the small bowel, which explains why small-bowel follow-through was the initial test performed. None of the patients was excluded from the study after this test was performed, and no adverse events were reported during or after the capsule procedure. Thus, on the basis of this initial group, it would seem that in very early or suspected Crohn's disease with no clinical evidence of small-bowel obstruction, there is no fear of ingesting the M2A capsule, but this needs to be confirmed by large-scale studies. The overall capsule non-natural excretion rate reported by Given Imaging Ltd in over 10000 capsule ingestions is 0.75%, sometimes necessitating surgical removal. This may happen in patients with Crohn's disease as well. We compared the M2A capsule with the small-bowel follow-through and CT (but not with enteroclysis) because these are the routine methods of investigation currently used by most physicians

and gastroenterologists worldwide. We are unaware of other studies using the M2A capsule in patients with suspected Crohn's disease. Keymling *et al.* [12] compared the capsule with barium enema and magnetic resonance imaging (MRI) investigations of the small bowel in patients with Crohn's disease, but this study is in abstract form only and no details are available.

In conclusion, the M2A capsule seems to be an effective, sensitive and valuable diagnostic tool in the early diagnosis of Crohn's disease. It is conceivable that it will become the first line of investigation in patients with early or suspected Crohn's disease.

### References

- 1 Goldberg HI, Caruthers SB Jr, Nelson JA, Singleton JW. Radiographic findings of the National Cooperative Crohn's Disease Study. *Gastroenterology* 1979; 77:925-937.
- 2 Meyers SG, Ruble PE, Ashley LB. The clinical course of regional enteritis. *Am J Dig Dis* 1959; 4:341-351.
- 3 Nolan DJ. The true yield of the small-intestinal barium study. *Endoscopy* 1997; 29:447-453.
- 4 Carlson HC. Perspective: the small bowel examination in the diagnosis of Crohn's disease. *Am J Roentgenol* 1986; 147:83-85.
- 5 Lipson A, Bartram CI, Williams CB, Slavin G, Walker-Smith J. Barium studies and ileoscopy compared in children with suspected Crohn's disease. *Clin Radiol* 1980; 31:591-596.
- 6 Rubesin SE, Scotinoplis I, Birnbaum BA, Ginsberg GG. Radiologic and endoscopic diagnosis of Crohn's disease. *Surg Clin North Am* 2001; 81:39-70.
- 7 Iddan G, Meron G, Glukhovky A, Swain P. Wireless capsule endoscopy. *Nature* 2000; 405:417-418.
- 8 Appleyard M, Fireman Z, Glukhovsky A, Jacob H, Schreiber R, Kadirkamanathan S, *et al*. A randomized trial comparing wireless capsule endoscopy with push enteroscopy for detection of small bowel lesions. *Gastroenterology* 2000; 119:1431-1438.
- 9 Lewia BS, Swain P. Capsule endoscopy in the evaluation of patients with suspected small intestinal bleeding: the results of a pilot trial. *Gastrointest Endosc* 2002; 56:349-353.
- 10 Scapa ES, Fireman ZF, Jacob HJ, Lewkowicz S, Migdal M, Get D, *et al*. Results of the first clinical studies performed in Israel with the wireless capsule endoscopy. *Endoscopy* 2001; 33 (suppl):A1940.
- 11 Cirillo LC, Camara L, Della Noce M, Castiglione F, Mazzacca G, Salvatore M. Accuracy of enteroclysis in Crohn's disease of the small bowel: a retrospective study. *Eur Radiol* 2000; 10:1894-1898.
- 12 Keymling M, Rosenstock U, Reister A, Herzig F. Capsule endoscopy versus barium enema and MRI investigation of the small bowel in patients with Crohn's disease. *Endoscopy* 2001; 33:A2699.

	A	B	C	D	E
1	<b>GI TRACT IMAGING (CAPSULE ENDSCOPY)</b>	<b>CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE</b>		911XX	
2				Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report	
3				Global -> XXX	
4				Location ->	Office
5	<b>TOTAL RN/LPN/MTA CLINICAL LABOR TIME</b>	RN/LPN/MTA	73	3	
6	<b>TOTAL RN CLINICAL LABOR TIME</b>				
7	PRE-SERV CLINICAL LABOR TIME	RN/LPN/MTA	5	0	
8	CON SED CLINICAL LABOR TIME	RN			
9	SERVICE PERIOD CLINICAL LABOR TIME	RN/LPN/MTA	65		
10	POST-SERV CLINICAL LABOR TIME	RN/LPN/MTA	3	3	
11	<b>PRE-SERVICE</b>				
12	Complete pre-service diagnostic & referral forms	RN/LPN/MTA	5		
13	Coordinate pre-surgery services - review tests	RN/LPN/MTA			
14	Schedule space and equipment in facility	RN/LPN/MTA			
15	Pre service education, consent	RN/LPN/MTA			
16	Phone calls & prescriptions	RN/LPN/MTA			
17	Other Clinical Activity (please specify)				
18	<b>SERVICE PERIOD</b>				
19					
20	Prep equip—data recorder, sensors, workstation	RN/LPN/MTA	21		
21	Greet patient and provide gowning	RN/LPN/MTA	3		
22	Obtain vital signs	RN/LPN/MTA	3		
23	Shave abdomen, chest	RN/LPN/MTA	2		
24	Patient instructions, diary	RN/LPN/MTA	0		
25	Prep patient—apply sensor array, fit belt	RN/LPN/MTA	7		
26	Capsule ingestion	RN/LPN/MTA	2		
27	Observe patient	RN/LPN/MTA	2		
28	patient phone call (1 out of every three patients)	RN/LPN/MTA	1		
29	greet and gown on return	RN/LPN/MTA	3		
30	Disconnect belt, recorder and sensor array	RN/LPN/MTA	5		
31	Discuss feedback, patient diary, instructions	RN/LPN/MTA	2		
32	<b>After patient leaves</b>				
33	Disinfect equipment	RN/LPN/MTA	5		
34	Download data to workstation	RN/LPN/MTA	5		
35	Create image archive	RN/LPN/MTA	2		
36	Recharge batteries and disinfect equipment	RN/LPN/MTA	2		
37					
38	<b>Post Service</b>				
39	Follow up phone call		3	3	
40					
41	<b>MEDICAL SUPPLIES</b>				
42	M2A 10-Pak supply kit (Given Imaging, 20451) - 10 capsules, 10 application kits (10 sensor array sleeves, 2 pads, 10 razors, 1 marker) Each kit costs \$4500, therefore, the per patient cost is \$450		\$450	1	
43					
44					
45	<b>EQUIPMENT</b>				
46	Workstation kit - Computer workstation with 17" color display, keyboard and mouse, color InkJet printer, RAPID Application software license (1 per workstation), system access (cables, adapters, connection box, documentation) Given Imaging #40440		\$17,000	176 minutes (based on 21 minutes of equipment prep time, 75 minutes of time to download the data from the recorder, and 80 minutes of physician reading time.)	
47	Data Recorder 15 kit - 1 data recorder DR 15, 1 sensor array, 2 battery packs, 1 battery charger, 1 recorder belt, 1 carrying case, 1 sensor location guide, 1 measuring tape Given Imaging #40144		\$6,950	545 minutes (based on 480 minutes patients wears the recorder and 65 of clinical staff service period time.)	
48	RAPID Booster kit - 1 booster, 4 USB cables, 1 USB 2 card, 1 Booster Given Imaging #FGS-0002		\$2,500	75 minutes of download time. (This kit speeds up the time to download the data from the recorder to the workstation.)	

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE  
SUMMARY OF RECOMMENDATIONS

February 2003

**Refilling of Implantable Infusion Pumps**

*September 2002 RUC Recommendation*

In November 2001, CPT created a new code 95990, *Refilling and maintenance of implantable pump or reservoir for drug delivery; spinal (intrathecal, epidural) or brain (intraventricular)*. Although some providers were reporting this service with CPT code 96530, *Refilling and maintenance of an implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)*, the specialty indicated that this code was inappropriately utilized. The physician services that are described by CPT code 95990 should have been previously reported using code 64999, *Unlisted procedure, nervous system*. Code 95990 describes a service requiring direct physician involvement and therefore, the service should have an assigned work value. The RUC clarified with the presenters that the physician and a registered nurse typically provide the service together. With this in mind, the RUC recommended that code 95990 include an editorial note to indicate that the physician is always present during the performance of this service.

A coalition of several specialties, including pain medicine, anesthesiology, neurosurgery, and spine surgery reviewed and surveyed the new CPT code 95990. A survey median of 1.82 was collected from 67 physicians, who indicated a pre-service time of 10 minutes, an intra-service time of 20 minutes, and a post-service time of 10 minutes. After the review of survey responses, the societies felt that the median survey value (1.82) was too high, therefore, the specialty society recommended 1.38, which is between the 25<sup>th</sup> percentile (1.11) and the median. The RUC did not agree that a work RVU of 1.38 was appropriate.

Although this code is billed often with an E/M code, the RUC understood that the survey respondents were surveyed for the specific work of the service only. The group identified relatively similar services for which they could compare work, time, and intensity. The RUC focused its comparison on two codes, 67500 *Retrobulbar injection; medication (separate procedure, does*

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

*not include supply of medication*) (Work RVU = 0.79) and 62252 *Reprogramming of programmable cerebrospinal shunt* (Work RVU = 0.74). The RUC surveyed the physician time for the 62252 is 15 minutes pre-service time, 20 minutes intra-service time, and 10 minutes post-service time. This was comparable to the time for 95990 and the RUC agreed that 62252 serves as a good cross comparison to this new code. **The RUC recommended the work RVU of 0.77 for CPT code 95990.**

#### *February 2003 RUC Recommendation*

In November 2002, CPT created the new code 95991 to specifically indicate administration by a physician. Since the creation of the new code clarified the role of the physician, the RUC agreed with the specialty societies that the work value for CPT code 95990, *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular)*;, should be changed to 0.00 work RVUs from the previous recommendation of 0.77. The RUC also agreed that, for CPT code 95991, *administered by physician or under direct supervision of physician*, the previous RUC recommendation for 95990 of 0.77 work RVU, should be crosswalked to code 95991. The physician time for the code includes 10 minutes of pre-service time, 20 minutes of intra-service time, and a post-service time of 7 minutes. **The RUC recommends a work relative value for CPT code 95990 of 0.00 and a work relative value of 0.77 for CPT code 95991.**

Per the request of the RUC, the CPT Editorial Panel revised the wording to delete the wording “or under direct supervision of physician.”

#### **Practice Expense**

The practice expense inputs for code 95990 and 95991 are the same and these inputs were approved at the April 2002 RUC meeting.

<b>CPT Code (●New)</b>	<b>Tracking Number</b>	<b>CPT Descriptor</b>	<b>Global Period</b>	<b>Work RVU Recommendation</b>
95990	R1	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular);	XXX	0.00
●95991	R2	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), administered by physician	XXX	0.77

*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: 95991 Tracking Number: R2 Global Period: XXX RUC Recommended RVW:0.77

**CPT Descriptor:**

Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), administered by physician

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** The typical patient is a 45 year old female with severe cancer-related pain. She has failed to obtain adequate pain relief without intolerable side effects from multiple trials of systemic medications, both narcotic and non-narcotic, as well as various blocks and injections. It is judged that the pain would not be improved by any further surgical resection, radiation therapy, and/or chemotherapy. A trial of an intrathecal infusion of morphine gave 80% pain relief at low dose rates. A permanent implanted subcutaneous programmable infusion pump was placed as well as an implanted intrathecal infusion catheter for a long-term intrathecal infusion of narcotic.

**Description of Pre-Service Work:** The solution to be injected into the pump/reservoir is ordered by the physician from the appropriate pharmacy. The order is to specify the name of the drug, the volume of the solution, the concentration of the solution, and the nature of the drug (preservative-free).

**Description of Intra-Service Work:** The center of the implanted subcutaneous continuous infusion pump or reservoir is palpated and identified. This center point is marked on the skin. The entire area over the pump or reservoir is then carefully prepped with iodine or alcohol. Throughout all this procedure, sterile technique is meticulous to prevent infection in the infusion solution, which would cause life-threatening meningitis. A special pump refill kit is then opened and an extra 20 cc syringe, 20 gauge needle, and 4x4 sponge added to the kit. Sterile gloves are then donned and a sterile drape with an open center area is taken from the refill kit and placed over the pump, being sure that all skin in the exposed center area has been prepped with iodine or alcohol.

Using sterile technique, the previously prepared drug to be injected into the pump or reservoir is then drawn from its transport or commercially-prepared vial into one of the 20 gauge needles. The solution's container is checked to be sure that the drug, the drug volume, and the drug's concentration are all correct according to what was ordered.

The 22g Huber needle in the refill kit is then attached to the overpressurization T-tubing in the kit and the tubing's stopcock closed. The Huber needle is then carefully, under sterile conditions, punctured through the skin over the center of the pump or reservoir. The needle is advanced and probed to find the actual center of the pump or reservoir and then the needle is advanced through the injection septum of the pump or reservoir to the proper depth. Once the needle has been positioned in the pump/reservoir, an empty 20 cc (or other appropriate volume) syringe is attached to the needle's tubing, stopcock opened, and the pump/reservoir emptied of its contents. The volume of the solution removed from the pump/reservoir is measured and checked against the medical records and/or pump status printout to be sure that the entire volume of the pump/reservoir has been removed. Failure to remove all the fluid can result in overfilling the pump/reservoir with the new solution and damage to the pump/reservoir or even pump/reservoir malfunction causing a potentially life-threatening intrathecal overdose of narcotic or baclofen to the patient. The stopcock is closed, the syringe removed, the syringe containing the new solution attached to the tubing, and the stopcock re-opened. The solution is then slowly over several minutes, injected into the pump/reservoir. It is double-checked that the correct volume has been injected into the pump/reservoir and then any possible overpressurization of the pump/reservoir is checked by turning the stopcock to allow pump solution to flow into the tubing's T-piece. This step of checking to avoid injecting too much solution and checking for overpressurization are critical to prevent overfilling the pump, which again could cause pump malfunction and/or sudden intrathecal overdosage of the drug that could be life-threatening.

**Description of Post-Service Work:** Once the T-tubing overpressurization check has been completed, the needle and tubing assembly are withdrawn from the pump and the skin. A sterile sponge is used to dry the skin and seal the puncture area. A band-aid is placed over the puncture spot. Excess iodine or alcohol is wiped from the surrounding skin. The contaminated needles, tubing, syringes, sponge, and gloves are then properly disposed.

---

**SURVEY DATA:**

Presenter(s) Norman Cohen, MD, American Society of Anesthesiologists, Samuel Hassenbusch, MD, PHD, American Academy of Pain Medicine, Charles Mick, MD, North American Spine Society

Specialty(s): American Academy of Pain Medicine, American Society of Anesthesia, American Association of Neurological Surgeons, Congress of Neurological Surgeons

Sample Size: 4791\*\* Responses: 67 Response Rate: (%): 1.4% Median RVW: 1.82

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: \*\*

Surveys were sent out to all members of American Neuromodulation Society, the Pain Section of neurosurgery (AANS-CNS), and to implantable interventional pain medicine physicians of AAPM. Members of NASS and ASA were also notified of this survey on their web sites. It was difficult to determine the exact number of respondents that actually looked at the web site survey from those numbers. We used the total membership numbers because of this which make the response rate look very deflated.

25th Percentile RVW: 1.11 75th Percentile RVW: 2.00 Low: 0 High: 8.42

Median Pre-Service Time: 10 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 30 Low: 3 High: 90

Median Post-Service Time: 40 7

Level of Service by CPT Code N/A  
Total Time (List CPT Code & # of Visits)

Immediate Post Service Time: N/A

Critical Care: N/A

Other Hospital Visits: N/A

Discharge Day Mgmt.: N/A

Office Visits: N/A

---

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
62368	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion ( includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming	0.75

---

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

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

**TIME ESTIMATES (Median)**

	<u>New/Revis. CPT Code: 95991</u>	<u>Key Reference CPT Code: 62368</u>
Median Pre-Time	10	0
Median Intra-Time	20	30
Median Immediate Post-service Time	10- 7	0
Median of Aggregate Critical Care Times	N/A	
Median of Aggregate Other Hospital Visit Times	N/A	
Median Discharge Day Management Time	N/A	
Median of Aggregate Office Visit Times	N/A	

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.55	2.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.31	1.86
Urgency of medical decision making	3.25	2.00

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.36	2.29
Physical effort required	2.61	2.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.75	2.00
Outcome depends on the skill and judgement of physician	3.70	2.71
Estimated risk of malpractice suit with poor outcome	4.00	2.57

**INTENSITY/COMPLEXITY MEASURES**

CPT Code      Reference  
Service 1

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.19	2.50
Intra-Service intensity/complexity	3.48	3.33

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

The American Academy of Pain Medicine sent out surveys including four different societies and asked the members to fill out the RVS and PE surveys. The data was compiled and analyzed. The final results were presented to a committee of the Academy of Pain Medicine in a conference call. The data was discussed in great detail and a consensus was established as to what data to present to the AMA RVS, (RUC), committee. This data appears on this summary form.

The Recommended RVW of 1.38 was chosen based upon a building block methodology. Using existing times and an IWPUT of 0.047 produces an RVW of 1.38. IWPUT for some related codes are: 62284 = .047, 62270 = .042 and 62272 = .052. RVWs for these related codes are: 62284 - 1.18 RVWs, 62270 - 0.88 RVWs, 62272 - 1.01 RVWs. We believe that the 95991 survey median RVW of 1.82 is too high. The statistics show a high value of 8.42 with a 75<sup>th</sup> percentile of 2.0 so the curve is skewed to the high end which would drive the median higher than a normal distribution.

---

**FREQUENCY INFORMATION**

How was this service previously reported? 96530 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty AAPM  Commonly  Sometimes  Rarely

Specialty ASA  Commonly  Sometimes  Rarely

Specialty AANS-CNS  Commonly  Sometimes  Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAPM Frequency 15,600

Specialty ASA Frequency 23,250

Specialty AANS-CNS Frequency 8,400

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

Specialty AAPM Frequency 10,400

Specialty ASA Frequency 15,500

Specialty AANS-CNS Frequency 5,600

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

---

**AMA/Specialty Society Update Process  
RUC Summary of Recommendation  
XXX Global Period  
In Office Direct Inputs**

Sample Size: 4791      Response Rate: 1.4 (%)      Global Period: XXX

Tracking Number AJ1      Reference Code 1: 62368      Reference Code 2: 96530

Geographic Practice Setting %: Rural 10%    Suburban 35%    Urban 55%

Type of Practice %:    27% Solo Practice  
                              39% Single Specialty Group  
                              10% Multispecialty Group  
                              24% Medical School Faculty Practice Plan

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

Surveys were sent out to members of the North American Spine Society and American Society of Anesthesiologists web site. Surveys were sent to American Neuromodulation Society, American Academy of Pain Medicine, and Pain Section of American Association of Neurological Surgeons-Congress of Neurological Surgeons by either fax or email. The data were collated and analyzed. The data were then presented to the American Academy of Pain Medicine, American Society of Anesthesiologists, and American Association of Neurological Surgeons-Congress of Neurological Surgeons, and The North American Spine Society who called together their coding/socio-economic committees to further disseminate the information. A multi-specialty RVS practice expense committee, consisting of practitioners involved in both in-office and out-of-office interventional pain management in multiple practice settings in widespread geographic areas was utilized. The committees after much discussion and thought came to a consensus on the final data to present on this summary form and to the RUC.

The practice expense direct inputs for clinical staff, supplies and equipment for this code have been determined with the assumption that typically a separate E/M visit will also be coded on the same day. We have deleted necessary clinical staff activities such as obtaining vital signs and greeting and gowning of the patient that are captured under the E/M code to avoid duplication. Insurance refusal to cover the same day E/M visit would result in under-valuation of this code.

Please describe the clinical activities of your staff:

**Pre Service period** – An RN handles the order for the patient specific, custom formulated narcotic mixture. The RN receives the medication, confirms the correct formulation, records receiving the medication and assures safe storage until the procedure. When the medication has arrived the patient is contacted, instructions are reviewed and the pump refill is scheduled. We believe the recently developed 0-10 day global pre-service time for in office procedures of 18 minutes reflects these activities for the first pump refill. When the patient returns for repeat refills many of the staff activities remain constant, however the 7 minutes allotted by the PEAC for pre-service education/consent is less after the patient becomes familiar with the procedure.

**CPT Code: 95990 and 95991**  
**Specialty Society(s) American Academy of Pain Medicine**

We have accordingly decreased the final pre-service recommendation by 3 minutes (from 18 minutes to 15 minutes).

**Service period-** No time has been requested for greeting and gowning of the patient or for obtaining vital signs because this is captured by the E/M visit which typically occurs at the same time. An RN reviews the chart, prepares the room, equipment and supplies and positions the patient. The RN then assists the physician during the pump refill. We have recommended 10 minutes of time to assist the physician (one-half of the intra-service MD time). The patient is then monitored for approximately 30 minutes to assure that none of the narcotic has leaked from the pump into the subcutaneous tissue. We have recommended 10 minutes of RN monitoring time (one-third of the total) to account for multi-tasking.

**Post Service period** – One phone call is typically made following the refill for pump specific follow-up. Because an E/M visit will be coded at the same time and that code includes a follow-up phone call we have not included a separate call to avoid duplication.

**Supplies:** In-office supplies are fairly standard and include CPEP recommended supplies and supplies particular to this procedure. A standard E/M package is utilized but is accounted for in the E/M visit.

**Equipment:** A power exam table is utilized for the procedure.

Pre-Service Clinical Labor Activities:

Coordinate pre-procedure services (Check pump drug ordering is correct, Call in prescription/order, Obtain drug(s), Store drug(s) in safe location

Intra-Service Clinical Labor Activities:

Review charts  
 Greet patient and provide gowning  
 Obtain vital signs  
 Provide preservice education, obtain consent  
 Prepare room, equipment, supplies  
 Prepare and position patient, monitor patient

*Post Procedure:*

Monitor pt. following service/check tubes, monitors, drains  
 Clean room/equipment by physician staff  
 Check dressings & wound/ home care instructions/coordinate office visits/prescriptions

**Post-Service Clinical Activities**

Conduct phone calls/call in prescriptions

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
1033	RN	15	32		0.422/min
1130	RN/LPN/MA		3		0.317/min

**CPT Code: 95990 and 95991**  
**Specialty Society('s)American Academy of Pain Medicine**

\* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, provide full description, estimated cost, and cost source.

<b>HCFA's Medical Supply Code*</b>	<b>Medical Supplies</b>	<b>Quantity of Supplies</b>	<b>Units Used for Purchase</b>	<b>Cost Estimate and Source (if applicable)</b>
NEW	Medtronic refill kit/ Model 8551 SynchroMed refill kit	1 kit		28.00 each
14005	Sterile pair of gloves	1 pr	Box	0.89
11306	Surgical mask	1	Case	0.30
91409	20 cc syringes	2	Case	1.24 each .62
52305	Betadine pre sticks	1 pkg	Case	0.44
31508	4x4 sponge/gauze	1 pack	Case	1.47
31502	Band aid	1	Box	0.05
91402	20-gauge needle	2	Box	0.24
11102	Chuck pad	1	Case	0.05

\* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, provide full description, estimated cost, and cost source.

<b>HCFA's Equipment Code*</b>	<b>Medical Equipment</b>	<b>No. of units in practice</b>	<b>Minutes of use per procedure</b>	<b>Hours per week in use for all services</b>	<b>Cost Estimate and Source (if applicable)</b>
E11003	Power table		27		

**Type of Service: Evaluation/Management Services or Diagnostic Tests  
XXX Global Period**

**TYPE OF SERVICE: Surgical Procedures  
000 Global Period**

**SITE OF SERVICE: In-OFFICE**

<u>Clinical Services</u>	<u>Minutes</u>	<u>Staff Type – Circle</u>
<b>Pre-Service Period</b>		
<i>Start: Following visit when decision for surgery or procedure made</i>		
Complete pre-service diagnostic & referral forms	5	<u>RN</u>
Coordinate pre-procedure services	3	<u>RN</u>
Office visit before surgery/procedure Review test and exam results	0	
Provide pre-service education/obtain consent	4	<u>RN</u>
Follow-up phone calls & prescriptions	3	<u>RN</u>
Other Clinical Activity (please specify)	0	
<hr/> <i>End: When patient enters office for surgery/procedure</i>		
<b>Service Period</b>		
<i>Start: When patient enters office for surgery/procedure Pre-service services</i>		
Review charts	3	<u>RN</u>
Greet patient and provide gowning	0	
Obtain vital signs	0	
Provide pre-service education/obtain consent	0	
Prepare room, equipment, supplies	2	<u>RN</u>
Prepare and position patient/ monitor patient	2	<u>RN</u>
Sedate/apply anesthesia	0	
<i>Intra-service</i>		
Assist physician in performing procedure	10	<u>RN</u>
Monitor pt. following service/check tubes, monitors, drains	10	<u>RN</u>
Clean room/equipment by physician staff	3	<u>RN/LPN/MA</u>
Complete diagnostic forms, lab & X-ray requisitions	0	
Review/read X-ray, lab, and pathology reports	0	

**CPT Code: 95990 and 95991**  
**Specialty Society('s)American Academy of Pain Medicine**

Check dressings & wound/ home care instructions/coordinate office visits/prescriptions 5 RN

Other Clinical Activity (please specify)  
*End Patient leaves office*

**Post-Service**

Post-Op Visit (99212 x1) 0  
Phone calls/call in prescriptions 0

# Special CMS Requests

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Developmental Testing Services**

96110

CPT code 96110 describes limited developmental testing, not the routine preventative medicine developmental forms. The typical scenario is a parent will call concerning their child (i.e. concern of autism) and the pediatric office will ask the parent to come in and fill out a screening form, which will be scored by a nurse. The parent would discuss this at a future scheduled visit with the pediatrician. As this code only describes the administration of the test, there is no physician work associated with this code, **the RUC recommends a work relative value recommendation of 0.00 for 96110.**

96111

The RUC examined code 96111 *Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, e.g., Bayley Scales of Infant Development) with interpretation and report, per hour*. It was determined by the RUC after reviewing the reference code 99245 *Office consultation for a new or established patient, which requires these three components: a comprehensive history; a comprehensive examination; medical decision-making of high complexity* (Work RVU = 3.43) that the intra-service time of the surveyed code (intra-service time = 85 minutes) exceeds the intra-service time of the reference service code (intra-service time = 48 minutes). In addition, the RUC noted that the survey's complexity and intensity measures for the surveyed code were often higher than the reference code. Although the descriptor for 96111 clearly states that it is a "per hour" code, the median survey intra-service time was 85 minutes, which is counterintuitive to a code designed to be reported for each 60 minutes of service. Based on this survey anomaly, the RUC agreed that the 25<sup>th</sup> percentile is the appropriate recommendation since it has both an intra-service time of 60 minutes and a survey work RVU of 2.60, which approximates the current work RVU of 99244 (2.58), a lower level consultation code than the most frequently selected reference service code (99245). In addition, the RUC requested that the specialty develop a coding proposal to CPT to delete the language "*per hour*," so that the code descriptor adequately reflects the service. The RUC felt that this code should only be reported once rather than "per hour." **The RUC recommends a work relative value of 2.60 for 96111.**

Practice Expense

The RUC modified and accepted the direct practice inputs recommended by the specialty society for these codes which were based on PEAC accepted standards. The specialty society requests that CPT code 96100 not be included in the zero work pool.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
96110		Developmental testing; limited (eg, Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report	XXX	0.00
96111		Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, e.g., Bayley Scales of Infant Development) with interpretation and report, per hour	XXX	2.60

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

CPT Code: **96111**      Tracking Number: N/A      Global Period: **XXX**      Recommended RVW: **2.60**

**CPT Descriptor: Developmental testing; extended (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments, eg, Bayley Scales of Infant Development) with interpretation and report, per hour**

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: An eight-year-old boy with impulsive, overly active behavior and previously assessed "average" intelligence was referred for evaluation of 'attention deficit disorder.' He had reading and written expression skills at the end of first grade level. The patient received speech and language therapy during his attendance at Head Start when he was four years old.

Behavior and emotional regulation rating scales (completed by the parent and another adult observer) are typically provided at the time of an earlier evaluation and management service appointment. History, physical and neurological examination are also completed at that visit. For this patient, responses from those standardized rating scales completed by his father and teacher were reviewed at that visit.

Standardized testing was administered to confirm auditory and visual attention, short term and working memory as well as verbal and visual organization. Testing was administered for standard scores as well as structured observations of behavior. These observations were integrated with previous historical data to support and confirm the diagnosis. The physical and neurologic evaluation would be part of an associated evaluation and management visit.

Description of Pre-Service Work:

Prior to the initial appointment with the pediatric developmental and behavioral subspecialist, when the child's mother called to make the appointment, she mentioned that he had early chronic ear infections and tube placement. Since then, he has seemed to have difficulty hearing what is being said. The pediatric subspecialist called the mother to discern if this had been assessed by the child's primary care physician. She denied any further assessment as the primary care physician reassured her "this may be a sign of his attention deficits." After explaining to the mother that it could be very helpful to have the primary care physician see the patient again before an appointment with the pediatric subspecialist and then obtaining her permission to contact the primary care physician, the pediatric subspecialist called the primary care physician and suggested a hearing evaluation would be appropriate prior to the requested current assessment. The primary care physician agreed. Several weeks later, the primary care physician called the pediatric subspecialist and reviewed the results of the child's hearing evaluation and asked if the referral was still acceptable. The pediatric subspecialist accepted the referral and the appointment was scheduled.

Description of Intra-Service Work:

The pediatric subspecialist chose the Woodcock-Johnson Test of Cognitive Abilities, Third Edition as this instrument allows the assessment of 'verbal abilities,' 'visual-spatial' abilities, processing speed, short-term and long-term memory composite scores. Identification of large differences in these individual areas can identify co-morbid cognitive processing areas impacting the child's ability to maintain focused selective attention. The testing session began with the subtests emphasizing auditory and verbal memory and knowledge (Memory for Words, Auditory Working Memory, Verbal Ability, General Information). Visual processing was assessed next (Picture Recognition, Spatial Relations, Planning). Processing rates for verbal information (Retrieval Fluency) and then visual/fine motor skills (Visual Matching, Decision Speed) were assessed. Finally, 'fluid processing' was observed (Concept Formation). Throughout the 75 minute session (included three 5 minute break periods for the child to go to the restroom, obtain a snack with the physician, and check with his mother while in the company of the physician), the physician noted the child's expressive discourse language skills, seated posture, fidgetiness, signs of external and internal distractibility, apparent mental effort, mood and preferences for certain tasks. Hand

position during the pencil and paper tasks and fine motor control used while opening the snack packages and 'juice box' were specifically noted. After the testing, the responses were scored and the physician reviewed the results with the patient and his mother. The explanations were directed at the child and the mother individually so that each understood the testing results. The results indicated a significant difference between Verbal Ability and Concept Formation and the Visual/Spatial Composite score. A formal assessment of receptive and expressive language was suggested. The patient's awkward pencil grip and notably slow speed during the pencil and paper tasks, taken in the context of the history provided, supported a suggested referral to an occupational therapist for consultation. Observations made during the testing confirmed the 'hyperactivity' scale observations made by the patient's teacher and mother on the rating scales obtained by the primary care physician prior to the referral.

Description of Post-Service Work:

After the evaluation testing appointment, the physician wrote a report (included in the work of the 96111 code) describing the results of the testing and recommendations reflective of the results. The mother called two weeks later and said the school psychologist would not schedule a meeting to review the results for eight weeks. She gave permission for full communication with all pertinent school personnel. The physician called the school psychologist to explain the need for prompt review of the test results as the patient's current classroom modifications were minimal and exacerbating his weak auditory attention. The school psychologist said the classroom teacher could make interim changes, but the physician would have to talk with her directly. The physician contacted the teacher by telephone and described the rationale for the utility of the classroom modifications. The teacher said she would implement them if the school speech pathologist agreed. Two days later the school speech pathologist called the physician directly about the recommendation for an assistive technology device (FM trainer). She said the physician would have to write a separate letter requesting this device for the patient. The physician wrote the letter.

**SURVEY DATA**

<b>Presenter(s):</b>	Lynn Wegner, MD, FAAP				
<b>Specialty(s):</b>	American Academy of Pediatrics (AAP)				
<b>CPT Code:</b>	96111				
<b>Sample Size:</b>	87	<b>Response (N):</b>	30	<b>Response (%):</b>	34%
<b>Sample Type:</b>	Panel (Members of the AAP Section on Developmental and Behavioral Pediatrics)				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.20	2.60	3.43	3.43	3.50
<b>Pre-Service Evaluation Time:</b>	0.00	5.00	10.00	30.00	60.00
<b>Pre-Service Positioning Time:</b>	N/A	N/A	N/A	N/A	N/A
<b>Pre-Service Scrub, Dress, Wait Time:</b>	N/A	N/A	N/A	N/A	N/A
<b>Intra-Service Time:</b>	35.00	60.00	85.00	90.00	300.00
<b>Post-Service</b>	<b>Total Min*</b>		<b>CPT code / # of visits</b>		
<b>Immediate Post-time:</b>	42.50 (25 <sup>th</sup> percentile = 30.00)		N/A		
<b>Critical Care time/visit(s):</b>	N/A				
<b>Other Hospital time/visit(s):</b>	N/A				
<b>Discharge Day Mgmt:</b>	N/A				
<b>Office time/visit(s):</b>	N/A				

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE: 99245**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>2003 Work RVU</u>
99245	Office consultation for a new or established patient, with requires these three key components: a comprehensive history; a comprehensive examination; medical decision-making of high complexity	XXX	3.43

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

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

Number of respondents who choose Key Reference Code: 18 out of 30 = 60%

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 96111</u>	<u>Key Reference CPT Code: 99245</u>
Median Pre-Service Time	5.00	10.00
Median Intra-Service Time	60.00	48.00
Median Immediate Post-service Time	30.00	50.00
Median Critical Care Time		
Median Other Hospital Visit Time		
Median Discharge Day Management Time		
Median Office Visit Time		
<b>Median Total Time</b>	<b>95.00</b>	<b>108.00</b>

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.37	4.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.73	4.70
Urgency of medical decision making	4.63	4.47

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.63	4.63
Physical effort required	4.73	4.47

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.83	3.07
---	------	------

Outcome depends on the skill and judgement of physician	4.67	4.47
Estimated risk of malpractice suit with poor outcome	2.67	2.73

**INTENSITY/COMPLEXITY MEASURES**

New/Revised  
CPT Code:  
96111

Key Reference  
CPT Code:  
99245

**Time Segments (Mean)**

Pre-Service intensity/complexity	2.50	2.73
Intra-Service intensity/complexity	4.70	4.53
Post-Service intensity/complexity	2.50	2.80

**ADDITIONAL RATIONALE**

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

We conducted a panel survey of 87 physician members of the American Academy of Pediatrics (AAP) Section on Developmental and Behavioral Pediatrics. We received thirty completed surveys and analyzed the results via an expert panel made up of AAP and American Academy of Child and Adolescent Psychiatry (AACAP) representatives. This expert panel arrived at the final recommendation of 2.60, the survey's 25<sup>th</sup> percentile work RVU. This recommendation is based on the following rationale:

The descriptor for 96111 clearly states that it is a "per hour" code. However, the median survey intra-service time was 85 minutes, which is counterintuitive to a code designed to be reported for each 60 minutes of service. Based on this survey anomaly, we advocate that the 25<sup>th</sup> percentile is the appropriate recommendation since it has both an intra-service time of 60 minutes and a survey work RVU of 2.60, which approximates the current work RVU of 99244 (2.58), a lower level consultation code than the most frequently selected reference service code (99245).

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

X Other reason (please explain): Service is typically reported in conjunction with an evaluation and management code

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

	<u>Global period</u>	<u>RVU</u>	<u>Pre</u>	<u>Intra</u>	<u>Post</u>
99243	XXX	1.72	5	30	31

Typical vignette when reported in conjunction with 96111:

The patient and his mother meet with the consulting physician to establish their understanding of the testing and to review the history (developmental attainment and school performance) relevant to the diagnosis "Attention Deficit Disorder-Combined Type." Since this evaluation and management visit is comprised of greater than fifty percent counseling, time is considered the key factor in selecting the level of service. The patient and the consultant begin the objective testing session (the patient's mother watches the process through an observer's window in a separate room).

	<u>Global period</u>	<u>25<sup>th</sup> percentile: RVU</u>	<u>Pre</u>	<u>Intra</u>	<u>Post</u>
96111	XXX	2.60	5	60	30

The same physician is reporting both 99243 and 96111. Since there is no overlap in services described by these codes, there is no duplication of service as provided by a single physician.

### FREQUENCY INFORMATION

How was this service previously reported? 96111, which is presently unvalued for physician work (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty: Pediatrics \_\_\_\_\_ Commonly X Sometimes \_\_\_\_\_ Rarely

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Pediatrics \_\_\_\_\_ Frequency: ~25,000-30,000

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty: Pediatrics \_\_\_\_\_ Frequency: The RUC database reports the 1999 frequency of 96111 to be 947

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Do many physicians perform this service across the United States? X Yes \_\_\_\_\_ No

**AMA/Specialty Society Update Process  
RUC Summary of Recommendation  
XXX Global Period  
In Office Direct Inputs**

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

Tracking Number: N/A                      Reference Code 1: N/A                      Reference Code 2: N/A

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %:    \_\_\_\_\_ Solo Practice  
                                  \_\_\_\_\_ Single Specialty Group  
                                  \_\_\_\_\_ Multispecialty Group  
                                  \_\_\_\_\_ Medical School Faculty Practice Plan

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

**Representatives from the American Academy of Pediatrics (AAP) and the American Psychological Association (APA) convened an expert panel to develop direct practice expense recommendations.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:                      **None**

Intra-Service Clinical Labor Activities:                      **Scoring completed developmental screening tool**

Post-Service Clinical Labor Activities:                      **None**

CMS' Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
7129	RN/LPN	0.00	15.00	0.00	

\*From CMS' Labor, Medical Supply, and Equipment List. If not listed, provide full description, estimated cost, and cost source.

CMS' Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
N/A	Ages And Stages Questionnaire (ASQ)	1 unit		\$0.40 Source: Paul J. Brookes, Publishers, PO Box 10624, Baltimore, MD 21285, 800/638-3775, <a href="http://www.pbrookes.com">www.pbrookes.com</a> ; stock #370X, \$190.00 for 19 kits but publisher allows photocopying of up to 25 additional copies of each kit for use with other patients; \$190.00/(19x25)=\$0.40 per patient

\* From CMS' Labor, Medical Supply, and Equipment List. If not listed, provide full description, estimated cost, and cost source.

CMS' Equipment Code*	Medical Equipment	Cost Estimate and Source (if applicable)
	N/A	

**Type of Service: Evaluation/Management Services or Diagnostic Tests  
XXX Global Period**

**SITE OF SERVICE: In-Office  
Clinical Services**

**Minutes      Staff Type – Circle**

**Pre-Service Period**

*Start: When appointment for service is made*

Review/read X-ray, lab, and pathology reports

\_\_\_\_\_ RN, LPN, MTA, Other

Other Clinical Activity (please specify)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ RN, LPN, MTA, Other

*End: Patient arrival at office for service*

**Service Period**

*Start: Patient arrival at office for service*

Greet patient/provide gowning

\_\_\_\_\_ RN, LPN, MTA, Other

Obtain vital signs

\_\_\_\_\_ RN, LPN, MTA, Other

Prep and position patient

\_\_\_\_\_ RN, LPN, MTA, Other

Prepare room, equipment, supplies

\_\_\_\_\_ RN, LPN, MTA, Other

Assist physician during exam

\_\_\_\_\_ RN, LPN, MTA, Other

Education/instruction/ counseling

\_\_\_\_\_ RN, LPN, MTA, Other

Coordinate home or outpatient care

\_\_\_\_\_ RN, LPN, MTA, Other

Clean room/equipment

\_\_\_\_\_ RN, LPN, MTA, Other

Other Clinical Activity (please specify):

**Scoring completed developmental screening tool**

**15**      RN, LPN, MTA, Other

*End: Patient leaves office*

**Post-Service Period**

*Start: Patient leaves office*

Phone calls between visits with patient, family pharmacy

\_\_\_\_\_ RN, LPN, MTA, Other

Other Activity (please specify)

\_\_\_\_\_

*End: When appointment for next office visit is made.*

\_\_\_\_\_ RN, LPN, MTA, Other

**AMA/Specialty Society Update Process  
RUC Summary of Recommendation  
XXX Global Period  
In Office Direct Inputs**

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

Tracking Number: N/A                      Reference Code 1: N/A                      Reference Code 2: N/A

Geographic Practice Setting %: Rural \_\_\_\_      Suburban \_\_\_\_                      Urban \_\_\_\_

Type of Practice %:      \_\_\_\_ Solo Practice  
                                  \_\_\_\_ Single Specialty Group  
                                  \_\_\_\_ Multispecialty Group  
                                  \_\_\_\_ Medical School Faculty Practice Plan

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

**Representatives from the American Academy of Pediatrics (AAP) and the American Psychological Association (APA) convened an expert panel to develop direct practice expense recommendations.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:                      **Phone call to patient/parent once referral from primary care physician received; review developmental screening results from primary care physician**

Intra-Service Clinical Labor Activities:                      **None**

Post-Service Clinical Labor Activities:                      **None**

CMS' Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
1130	RN/LPN/MTA	3.00	0.00	0.00	

\*From CMS' Labor, Medical Supply, and Equipment List. If not listed, provide full description, estimated cost, and cost source.

CMS' Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
N/A	Woodcock Johnson Test of Cognitive Abilities (WJ-TCA), Third Edition, Test Record	1 unit		\$2.44 Source: Paul J. Brookes, Publishers, PO Box 10624, Baltimore, MD 21285, 800/638-3775, <a href="http://www.pbrookes.com">www.pbrookes.com</a> ; stock #9-23610, \$61.00 for 25 kits; \$61.00 divided by 25=\$2.44 per patient

\* From CMS' Labor, Medical Supply, and Equipment List. If not listed, provide full description, estimated cost, and cost source.

CMS' Equipment Code*	Medical Equipment	Cost Estimate and Source (if applicable)
N/A	Woodcock Johnson Test of Cognitive Abilities (WJ-TCA), Third Edition, Standard Cognitive Abilites Battery and Compuscore and Profiles Program	\$727.50 Source: Paul J. Brookes, Publishers, PO Box 10624, Baltimore, MD 21285, 800/638-3775, <a href="http://www.pbrookes.com">www.pbrookes.com</a> ; stock #9-23610 and stock #9-23540

**Type of Service: Evaluation/Management Services or Diagnostic Tests  
XXX Global Period**

**SITE OF SERVICE: In-Office  
Clinical Services**

**Minutes      Staff Type – Circle**

**Pre-Service Period**

*Start: When appointment for service is made*

Review/read X-ray, lab, and pathology reports

\_\_\_\_\_ RN, LPN, MTA, Other  
\_\_\_\_\_

Other Clinical Activity (please specify):

**Phone call to patient/parent once referral from primary care physician received**

\_\_\_\_\_ RN, LPN, MTA, Other  
\_\_\_\_\_

**Review developmental screening results from primary care physician**

\_\_\_\_\_ RN, LPN, MTA, Other  
\_\_\_\_\_

*End: Patient arrival at office for service*

**Service Period**

*Start: Patient arrival at office for service*

Greet patient/provide gowning

\_\_\_\_\_ 3 \_\_\_\_\_ **RN, LPN, MTA, Other**  
\_\_\_\_\_

Obtain vital signs

\_\_\_\_\_ RN, LPN, MTA, Other  
\_\_\_\_\_

Prep and position patient

\_\_\_\_\_ RN, LPN, MTA, Other  
\_\_\_\_\_

Prepare room, equipment, supplies

\_\_\_\_\_ RN, LPN, MTA, Other  
\_\_\_\_\_

Assist physician during exam

\_\_\_\_\_ RN, LPN, MTA, Other  
\_\_\_\_\_

Education/instruction/ counseling

\_\_\_\_\_ RN, LPN, MTA, Other  
\_\_\_\_\_

Coordinate home or outpatient care

\_\_\_\_\_ RN, LPN, MTA, Other  
\_\_\_\_\_

Clean room/equipment

\_\_\_\_\_ RN, LPN, MTA, Other  
\_\_\_\_\_

Other Clinical Activity (please specify):

\_\_\_\_\_ RN, LPN, MTA, Other  
\_\_\_\_\_

*End: Patient leaves office*

**Post-Service Period**

*Start Patient leaves office*

Other Activity (please specify)

\_\_\_\_\_ RN, LPN, MTA, Other  
\_\_\_\_\_

*End: When appointment for next office visit is made.*

AMA Specialty Society Recommendation

	A	B	C	D	E	F
1						
2	Direct PE Recommendations, April 2003 RUC		96110		96111	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Developmental testing; limited, with interpretation and report		Developmental testing; extended, with interpretation and report, per hour	
4	LOCATION		In Office	Out Office	In Office	Out Office
5	GLOBAL PERIOD					
6	TOTAL CLINICAL LABOR TIME	1130 (RN/LPN/MTA)	15.0	0.0	3.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		15.0	0.0	3.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		0.0	0.0	0.0	0.0
10	PRE-SERVICE					
11	Start: Following visit when decision for surgery or procedure made					
12	Complete pre-service diagnostic & referral forms					
13	Coordinate pre-surgery services					
14	Schedule space and equipment in facility					
15	Office visit before surgery/procedure Review test and exam results					
16	Provide pre-service education/obtain consent					
17	Follow-up phone calls & prescriptions					
18	Other Clinical Activity (please specify)					
19	Phone call to patient/parent once referral from primary care physician received					
20	Review developmental screening results from primary care physician					
21	Review/read X-ray, lab, and pathology reports					
22	End:When patient enters office/facility for surgery/procedure					
23	SERVICE PERIOD					
24	Start: When patient enters office/facility for surgery/procedure					
25	Pre-service services					
26	Review history, systems, medications					
27	Greet patient and provide gowning				3	
28	Obtain vital signs					
29	Provide pre-service education/obtain consent					
30	Prepare room, equipment, supplies					
31	Prepare and position patient					
32	Sedate/apply anesthesia					
33	Intra-service					
34	Assist physician in performing exam					
35	Education/instruction/counseling					
36	Scoring completed developmental screening tool		15			
37	Post-Service					
38	Monitor pt following service/check tubes, monitors, drains					
39	Clean room/equipment by physician staff					
40	Complete diagnostic forms, lab & X-ray requisitions					
41	Review/read X-ray, lab, and pathology reports					
42	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
43	Coordinate home or outpatient care					
44	Discharge day management 99238 --12 minutes 15 minutes	99239 --				
45	Other Clinical Activity (please specify)					
46	End: Patient leaves office					
47	POST-SERVICE Period					
48	Start: Patient leaves office/facility					
49						
50	Office visits Greet patient,escort to room, provide gowning, interval history & vital signs and chart, assemble previous test reports/results,assist physician dunnng exam, assist with dressings, wound care, suture removal, prepare dx test, prescription forms, post service education, instruction, counseling, clean room/equip, check supplies, coordinate home or outpatient care					
51	List Number and Level of Office Visits					
52	99211 16 minutes	16				
53	99212 27 minutes	27				
54	99213 36 minutes	36				
55	99214 53 minutes	53				
56	99215 63 minutes	63				
57	Other					
58						
59	Total Office Visit Time		0	0	0	0
60	Other Activity (please specify)					
61	End: with last office visit before end of global period					

	A	B	C	D	E	F
2	Direct PE Recommendations; April 2003 RUC		96110		96111	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Developmental testing; limited, with interpretation and report		Developmental testing; extended, with interpretation and report, per hour	
4	LOCATION		In Office	Out Office	In Office	Out Office
62	MEDICAL SUPPLIES					
63	Developmental screening tools:					
64	Ages And Stages Questionnaires (ASQ); \$0.40, Source: Paul J. Brookes, Publishers, PO Box 10624, Baltimore, MD 21285, 800/638-3775, www.pbrookes.com; stock #370X, \$190.00 for 19 kits but publisher allows photocopying of up to 25 additional copies of each kit for use with other patients; \$190.00/(19x25)=\$0.40 per patient		1			
65	Woodcock Johnson Test of Cognitive Abilities (WJ-TCA), Third Edition, Test Records; \$2.44, Source: Paul J. Brookes, Publishers, PO Box 10624, Baltimore, MD 21285, 800/638-3775, www.pbrookes.com; stock #9-23610, \$61.00 for 25 kits; \$61.00 divided by 25=\$2.44 per patient				1	
66						
67						
68						
69						
70	Equipment					
71	Woodcock Johnson Test of Cognitive Abilities (WJ-TCA), Third Edition, Standard Cognitive Abilities Battery and Compuscore and Profiles Program, \$727.50, Source: Paul J. Brookes, Publishers, PO Box 10624, Baltimore, MD 21285, 800/638-3775, www.pbrookes.com; stock #9-23610 and stock #9-23540				1	

# CPT 2003 Interim Values

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2002 and February 2003

**Mohs Micrographic Surgery**

*RUC Recommendation from April 2002:*

For CPT 2003, the American Academy of Dermatology recommended changes that would clarify that a biopsy and frozen pathology could be done on the same day as Mohs surgery. In addition, the specialty proposed changes to special procedures such as decalcification of the bone during Mohs surgery or specialty stains (i.e. immunostaining for melanoma). Finally, modifications to code 17310 were recommended to clarify that each specimen after the first 5 specimens in each layer is separately reimbursable. The Center's for Medicare and Medicaid recommended that the work value for 17310 be changed from 000 to ZZZ. CPT approved these changes.

Modification to codes 17304, 17305, 17306, and 17307 were considered editorial changes, and were not reviewed by the RUC. The specialty survey for code 17310 did not provide calculations that were work neutral. In addition, RUC members were unclear on the historical information regarding whether the code could be billed more than one time on the same day for greater than 5 specimens, as the interpretation from CPT differed from the interpretation put forth by CMS in 1994 letter from a CMS Chief Medical Officer. Therefore, the RUC approved a motion to let the value stand for the CPT 2003 cycle as interim. Between the April 2002 RUC Meeting and the February 2003 RUC Meeting, an ad-hoc committee would further clarify with CPT the intent of code 17310. In addition, the specialty society would revise their survey based on the agreed upon interpretation of the descriptor and the new ZZZ global period.

**The RUC recommends an interim work relative value for CPT code 17310 of 0.95.**

Practice Expense

The RUC referred practice expense inputs for this family of codes to the September 2002 Practice Expense Advisory Committee.

*RUC Recommendation from February 2003:*

A workgroup of the RUC reviewed this issue at the February 2003 meeting and concluded that a number of issues should be addressed regarding these services, including:

- The code descriptors for these services remain confusing and open to various interpretations. Although the RUC understands that many in the Mohs community and payors had historically interpreted CPT code 17310 as an add-on code to be reported for each additional specimen beyond the first five specimens, concern was expressed regarding the potential for over-utilization of this code. In addition, the workgroup noted that the nomenclature for these services is not consistent with other integumentary coding conventions in CPT, which are based on the size of the lesion, rather than the number of specimens. The RUC, therefore, recommends that the specialty work with the CPT Editorial Panel to re-define the Mohs Micrographic Surgery section in CPT. After this revision is complete, the RUC believes that these codes can be appropriately re-evaluated.
- In the interim, the RUC recommends that CMS retain the 2002 work relative value of 0.95 for CPT code 17310. In the December 31, 2002 *Final Rule*, CMS had published that it had reduced the RUC's interim recommendation of 0.95 to 0.62. CMS concluded that intent of the code had changed as it will now be described as an add-on code. The RUC believes that CMS should research its past policies regarding this code, as the specialty has provided documentation that CMS had already been under the assumption that this service was an add-on and could be reported once for each additional specimen beyond the first five specimens. Specifically, the specialty has referred to the November 25, 1991 *Final Rule*, which states that "Code 17310, which is described as *Mohs', more than 5 specimens, fixed or fresh tissue, any stage*, should be treated as a single specimen; that is, if more than 5 specimens are necessary at any stage, each additional specimen beyond 5 should be separately paid. The work RVUs have been established according to the above interpretation." The RUC is also concerned that CMS' approach to determining a new value of 0.62 may be flawed. CMS only considered the pathology work and the specialty has presented that the work of the additional excision should also be factored into the work relative value.
- The RUC's Practice Expense Advisory Committee had reviewed the direct practice expense inputs for these services in April 1999. The RUC recommends that these recommendations remain "interim" pending re-definition and re-evaluation of this family of codes.
- The workgroup that extensively examined this issue at the February 2003 meeting will be assigned to review this issue again after the codes are re-defined by CPT.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b>Surgery</b> <b>Integumentary System</b> <b>Mohs Micrographic Surgery</b> <i>Mohs Micrographic surgery, for the removal of complex or ill-defined skin cancer, requires a single physician to act in two integrated, but separate and distinct capacities: surgeon and pathologist. If either of these responsibilities is delegated to another physician who reports his services separately, these codes are not appropriate. If repair is performed, use separate repair, flap, or graft codes. <u>If a biopsy of a suspected skin cancer is performed on the same day as Mohs surgery because there was no prior pathology confirmation of a diagnosis, then report diagnostic skin biopsy (11100, 11101) and frozen section pathology (88331) with modifier -59 to distinguish from the subsequent definitive surgical procedure of Mohs surgery.</u></i>				
σ17304	M1	Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathological preparation <u>including the first routine stain (eg, hematoxylin and eosin, toluidine blue); first stage, fresh tissue technique, up to 5 specimens.</u>  <u>(If additional special pathology procedures, stains or immunostains are required, use 88311-88314, 88342)</u>	000	7.60 (no change)
σ17305	M2	<i>second stage, fixed or fresh tissue, up to five specimens</i>	000	2.85 (no change)
σ17306	M3	<i>third stage...</i>	000	2.85 (no change)
σ17307	M4	<i>additional stage(s),...</i>	000	2.85 (no change)
:σ17310	M5	<u>each additional specimen, <del>more than</del> after the first 5 specimens, fixed or fresh tissue, any stage (List separately in addition to code for primary procedure)</u>  <u>Use 17310 in conjunction with codes 17304-17307)</u>	ZZZ*  *Change in global from 000	0.95 (interim)

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April and September 2002

**Bone Marrow Procedures**

Thirteen new CPT codes were added and two were deleted to provide greater granularity to accurately code the specific procedures performed for each patient receiving bone marrow or stem cell transplantation. The newer techniques used in a transplant laboratory under physician supervision are now captured in these new CPT codes. CPT codes 38205-38215 replace codes 38231 *Blood-derived peripheral stem cell harvesting for transplantation, per collection* (Work RVU = 1.50) and 86915 *Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s)* (e.g., T-cells, metastatic carcinoma) to allow for different types, work, and techniques now used for different types of cell harvesting and also transplant preparation as well as the critical work and techniques involved in stem cell processing prior to a Bone Marrow Transplant. Present codes 38231 and 86915 were not designed for modern procedures in bone marrow transplant and have virtually no relevance to the present stem cell harvesting and processing work and procedures. The RUC understands that these services are not commonly performed on the Medicare population and very few centers perform these services (50 centers), therefore, the smaller number of survey respondents (21) was expected.

**38204 Management of recipient hematopoietic progenitor cell donor search and cell acquisition**

The RUC reviewed the survey results and the similarities in physician work of the reference code, 80502 *Clinical pathology consultation; comprehensive, for complex diagnostic problem, with review of patient's history and medical records* (Work RVU=1.33). The RUC believed that this service was more intense than 80502 as there was zero tolerance for error. The RUC understands that this newly reported service would be billed one time per recipient. The RUC also compared this service to CPT code 99204 *Office or other outpatient visit for the evaluation and management of a new patient ... a level 4 new patient office visit* representing 45 minutes of physician time (work RVU = 2.00). The RUC agreed that the time spent on this type of per patient management reflected the specialty's recommended 25<sup>th</sup> percentile surveyed intra-service time. The RUC agreed that there is no pre- and post-service time. **The RUC recommends a relative work value of 2.00 for CPT code 38204.**

**38205 Blood derived hematopoietic progenitor cell harvest for future transplantation per collection; allogeneic**

**38206 Blood derived hematopoietic progenitor cell harvest for future transplantation per collection; autologous**

These two codes were previously billed as code 38231 *Blood derived peripheral stem cell harvesting for transplantation, per collection* (Work RVU = 1.50). The specialty society recommended a value of 2.0 stating code 38231 had been undervalued. The

RUC however found no compelling evidence to increase the value, and believed it had been appropriately valued by the RUC when reviewed in 1995. **The RUC recommends a relative work value of 1.50 for CPT codes 38205 and 38206.**

**38210 & 38207 – 38215**

In April 2002, the RUC reviewed CPT code 38210 *Transplantation preparation of hematopoietic progenitor cells; cryopreservation and storage; specific cell depletion within harvest, T-cell depletion* as an anchor code for family 38205 through 38215. The RUC first recognized that the vignette did not reflect an accurate description of the service of 38210, however the RUC did believe that the work involved in code 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Work RVU = 0.94) was similar. The RUC also reviewed the codes in comparison to the work of evaluation and management services. The RUC was concerned regarding the accuracy of the survey data for these services. However, the RUC agreed that a repeated survey would not be appropriate as it would have to be circulated to the same physicians/centers. The RUC recommends that a consensus panel of physicians, with the participation of one or more RUC members, review these codes again for the September 2002 RUC meeting. The RUC however, felt strongly, that these services require physician work and recommends interim work values to be assigned for 38207-38215. The RUC emphasized that these interim values should not be viewed as a “ceiling” for the future review, but serve as the best alternative until future review is completed. Considering the similarities in work of code 86077 and 38210, the RUC had recommended an interim value of 0.94 for code 38210.

The RUC compared similarities in work and intensity of codes 86077 and 38210, and then agreed with the rank order established by the specialty society for the family of codes 38207 through 38215. The RUC agreed with the specialty society’s recommended rank order for the family, but also understood that the values being established were interim pending future RUC review and consideration at the September 2002 meeting. The RUC had recommended the following interim work relative values for CPT codes 38207-38215:

CPT Code	April 2002 Interim RUC Recommendation
38207	0.47
38208	0.56
38209	0.24
38210	0.94
38211	0.71
38212	0.47
38213	0.24
38214	0.24
38215	0.55

In September 2002, the RUC formed a facilitation committee to extensively discuss each of the services described in new CPT codes 38207 – 38215 and establish work relative value recommendations. The committee affirmed the decision made in April 2002 that these services do require direct physician involvement on a per patient level and should have assigned physician work. The RUC, however, remains concerned that the survey instrument and the corresponding summary of recommendation forms were not properly constructed. In addition, the RUC was concerned that further clarification is necessary in the CPT nomenclature for a few of these codes. Therefore, the RUC recommends that after further CPT revision, the specialty society conduct a re-survey of these services. The RUC proceeded to develop revised relative value recommendations, but will consider these relative values interim until the specialty society has the opportunity to re-survey.

In April, as an attempt to assign interim values, the RUC cross-walked the work relative value for 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (Work RVU = 0.94) to new CPT code 38210 *Specific cell depletion within harvest, T-cell depletion*. Work relative values were then extrapolated to the remaining codes in this family, utilizing the relativity established by the specialty society recommendations. In September, the specialty suggested, and the RUC agreed, that the 86077 should have been cross-walked to 38212 *Red blood cell removal*, rather than 38210. The RUC intra-service time for 86077 is 40 minutes, which is closer to the survey intra-time of 38212 (30 minutes) than is the survey intra-time of 38210 (60 minutes).

The RUC reviewed, in detail, the physician involvement and work in the service described in CPT code 38212. The physician work is as follows:

- Pre-work:** Reviewing data available prior to the time cells arrive in lab. This includes the phenotyping on donor and recipient; antibody information; and donor and recipient body weight. The committee agreed that the survey pre-time of 5 minutes seemed reasonable.
- Intra-work:** The intra-work begins when the cells arrive in the lab. The tech would get the Hct. The physician would then look at CD 34 (flow cytometry) on monitor. Based on the cell counts and Ab counts, the physician would decide which technique to use to deplete the red blood cells. The tech then does the process. After the bleed off of red blood cells, the physician judges where to divide the sample. A Hct and CD34 are repeated. The physician looks at the results and decides whether to recombine components and repeat the separation. The typical patient has this process one time through (without the recombining), about one-third require re-separation. The RUC agreed that 30 minutes of physician intra-service work was reasonable. This includes multiple flow cytometry readings, decision-making, and other interactions with the technician.

Post-work: Report and documentation. The RUC agreed that the specialties indication that this takes the form of a handwritten note is reasonable, given the detailed, sensitive information. The survey post-time of 15 minutes may be slightly overstated. The RUC agreed that 10 minutes of post-service time was reasonable for the written report.

The RUC noted several additional factors in walking through the physician involvement and work in providing this service:

- The procedure requires intermittent physician time, sometimes over several hours. During that time, the physician is interacting with the technicians intermittently to determine how best to process cells.
- The procedure does not involve face-to-face patient contact. It occurs in an isolated laboratory.
- Physician work related to this procedure includes quality assurance work to support quality assurance for the lab. Physicians have not historically been separately compensated for quality assurance in the lab. Therefore, it is legitimate to consider this work as part of the work of the procedure.
- The risks to the patient are real. Mistakes can cause patient death. This adds to the stress of the procedure and decision-making.

Doctor Paul Rudolf, from the Centers for Medicare and Medicaid Services, informed the committee that deleted CPT code 86915 *Bone marrow or peripheral stem cell harvest modification or treatment to eliminate cell type(s) (e.g., T cells, metastatic carcinoma)*, where the services described in 38210-38213 were previously reported is paid on the clinical lab fee schedule. He noted that currently the payment for 86915 is based on reasonable cost. The specialty and RUC agreed that CMS would need to make a technical correction to the cost reporting instructions to eliminate the physician compensation from these specific labs if compensation for the physician's professional service is included on the cost report. *Staff Note: Subsequent to the RUC meeting, the specialty determined that current program instructions provide for Code 86915 to be reimbursed on a reasonable charge basis when performed by independent laboratories and through the hospital outpatient prospective payment system when performed in outpatient departments. This information was shared with CMS.*

The RUC reviewed the proposed crosswalk of code 86077 *Blood bank physician services*, which has 40 minutes of intra-time and a work relative value of 0.94, to CPT code 38212. The RUC noted that since documentation is also required for 86077, the 40 minutes of intra-time may include some actual post-work. The RUC also agreed that the intensity of 38212 would be greater than 86077. After reviewing 38212 in detail, the RUC agreed that a comparison and cross-walk between 86077 and 38212 was reasonable.

The RUC also reviewed the appropriate work relative value for 38212 by using a building block method. CPT code 38212 includes two flow cytometry procedures. 88180 *Flow cytometry; each cell surface, cytoplasmic or nuclear marker* (work rvu = 0.36), includes a pre-time of 5 minutes, intra-time of 10 minutes, and post-time of 10 minutes. The RUC agreed that a multiple of two 88180, with

additional work for the interaction with the technician and the medical decision-making offered another validation of a work relative value of 0.94 for 38212. The RUC also recommends that a note be added to CPT to indicate that 88180 should not be reported in addition to this series of codes, as they include the work of flow cytometry.

**The RUC recommends a work relative value of 0.94 for CPT code 38212. The RUC recommends physician time of 5 minutes pre-time, 30 minutes intra-time, and 10 minutes post-time.**

The RUC then discussed the best way to extrapolate the appropriate value of 0.94 for 38212 to the rest of the family of codes. The RUC no longer agreed that the specialty society's recommended values were in the appropriate relativity, as these were derived from a very small consensus panel (two or three physicians). The survey medians appeared to correspond with the intra-service time for most services, so the committee agreed to use the survey medians for relativity. The RUC agreed that the intra-service survey time should be used, but felt that a standardized pre-time of 5 minutes, and standardized post-time of 10 minutes should be applied to all of the codes in this family. The RUC had significant concern, however, regarding the survey medians for three codes, 38208, 38209, and 38213. CPT code 38213 *Platelet depletion* was grossly overvalued by the survey respondents. CPT codes 38208 *thawing of previously frozen harvest* and 38209 *washing of harvest* should be referred back to CPT to create codes that describe thawing without washing and thawing with washing. The specialty had indicated a specimen must always be thawed before washing, so the current coding structure is not appropriate.

**The RUC, therefore, recommends the following for this family of services:**

- **CPT should add a note to this family of services to specify that CPT code 88180 *Flow cytometry* should not be reported in addition to these services as it is included in the valuation of these codes.**
- **CPT should review the coding language for codes 38208 and 38209, as thawing of the harvest must always occur prior to washing of the harvest. The codes should be formatted as thawing without washing and thawing with washing.**
- **After these changes have been made by the CPT Editorial Panel, the specialty should re-survey the entire family of services with the following improvements to the survey instrument:**
  - **a better reference service list, with other similar services included**
  - **better education of survey respondents regarding the survey process**
  - **better descriptions of the physician work involved**
  - **assistance from the RUC facilitation committee prior to dissemination of the survey instrument**
- **The work relative values developed at the September RUC meeting are more valid than the values developed in April, however, the values for CPT codes 38207 – 38215 should remain interim until after these codes have been re-surveyed and re-presented to the RUC.**

- A standardized pre-time of 5 minutes and post-time of 10 minutes should apply to each code. The survey median intra-service time should be recorded into the RUC database for all of the services.
- The work relative value for CPT code 38212 should be cross-walked from CPT code 86077 and the survey median relativity should be used to extrapolate work relative values to the rest of the services in the family, as follows:

CPT Code	September 2002 Interim RUC Recommendation
38207	0.89
38208	0.56
38209	0.24
38210	1.57
38211	1.42
38212	0.94
38213	0.24
38214	0.81
38215	0.94

**38242 Bone marrow or blood-derived peripheral stem cell transplantation; allogenic donor lymphocyte infusions**

The specialty presented a typical patient that is severely ill and in great risk. Approximately 25% of these procedures are complicated by life threatening reactions to the infusion. The RUC agreed with the specialties description of the intensity of intra-service work and 25<sup>th</sup> percentile time of 30 minutes.

The RUC also understood that this service could be compared to several other intense procedures including critical care code 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU = 2.0), however, the work for this code was not quite as intense, and could be more appropriately aligned with code 99357 *Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (eg, maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); each additional 30 minutes (List separately in addition to code for prolonged physician service)* (work RVU= 1.71) for its time and intensity. The RUC in addition, believed code 38242 was less intense than the reference code 38240 *Bone marrow or blood-derived peripheral stem cell transplantation; allogenic* (work RVU = 2.24, Harvard total time 53). **The RUC recommends a relative work value of 1.71 for code 38242**, which has the approval of the specialty society.

**Practice Expense:** The RUC and the specialty society agreed that these procedures do not have any practice expense inputs and are performed exclusively in the facility setting.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 38204	AV1	Management of recipient hematopoietic progenitor cell donor search and cell acquisition	XXX	2.00 (May 2002 RUC Recommendation)
● 38205	X1	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogenic	000	1.50 (May 2002 RUC Recommendation)
● 38206	X2	autologous	000	1.50 (May 2002 RUC Recommendation)
● 38207	X3	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage  (For diagnostic cryopreservation and storage, see 88240)	XXX	0.89 (Interim)
● 38208	X4	thawing of previously frozen harvest  (For diagnostic thawing and expansion of frozen cells, see 88241)	XXX	0.56 (Interim)
● 38209	X5	washing of harvest	XXX	0.24 (Interim)
● 38210	X6	specific cell depletion within harvest, T-cell depletion	XXX	1.57

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
				(Interim)
●38211	X7	tumor cell depletion	XXX	1.42 (Interim)
●38212	X8	red blood cell removal	XXX	0.94 (Interim)
●38213	X9	platelet depletion	XXX	0.24 (Interim)
●38214	X10	plasma (volume) depletion	XXX	0.81 (Interim)
●38215	X11	cell concentration in plasma, mononuclear, or buffy coat layer	XXX	0.94 (Interim)
<del>38231</del>		<del>Blood-derived peripheral stem cell harvesting for transplantation, per collection</del>  (38231 has been deleted. To report, use 38205-38206)	000	N/A
●38242	X12	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic donor lymphocyte infusions	XXX	1.71 (May 2002 RUC Recommendation))
<del>86915</del>		<del>Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (eg, T-cells, metastatic carcinoma)</del>  (86915 has been deleted. To report, use 38210-38213)	XXX	N/A

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



# THE AMERICAN SOCIETY OF HEMATOLOGY

1900 M Street, NW, Suite 200, Washington, DC 20036 ph 202 776 0544 fax 202 776 0545 e-mail ASH@hematology.org

## 2002

### President

Robert I Handin, M D  
Executive Vice Chairman, Department of  
Co-Director, Hematology Division  
Brigham & Women's Hospital  
75 Francis Street  
Boston, MA 02115-6110  
ph 617 732 5840  
fax 617 732 5706  
rhandin@partners.org

### President-Elect

Ronald Hoffman, M D  
University of Illinois - Chicago  
College of Medicine  
900 S Ashland Ave., M/C 734  
Chicago, IL 60607-4004  
ph 312 413 9308  
fax 312 413 7963  
ronhoff@uic.edu

### Vice President

Stanley L Schrier, M D  
Stanford University School of Medicine  
CCSR, Room 1155  
Stanford, CA 94305-5156  
ph 650 723 8688  
fax 650 736 0974  
sschrier@leland.stanford.edu

### Secretary

Nancy Berliner, M D  
Yale University School of Medicine  
of Hematology, WWW428  
dar Street  
New Haven, CT 06510  
ph 203 785 4144  
fax 203 785 7232  
nancy.berliner@yale.edu

### Treasurer

Andrew I Schafer, M D  
Department of Medicine  
Baylor College of Medicine  
6550 Fannin, SM 1423  
Houston, TX 77030  
ph 713 793 8300  
fax 713 793 8333  
aschafer@bcm.tmc.edu

### Councillors

Karl G Blume, MD  
Hal E Broxmeyer, Ph D  
George R Buchanan, M D  
Janice L Gabrilove, M D  
James N George, M D  
Armand Keating, M D  
Kanti R Rai, M D  
J Evan Sadler, M D, Ph D

### Editor-in-Chief

Kenneth Kaushansky, M D  
Division of Hematology  
University of Washington  
Box 357710, HSB K136  
Seattle, WA 98195-7710  
ph 206 685 7868  
fax 206 543 3560  
kkaushan@u.washington.edu

### Executive Director

Martha L Liggett, Esq  
The American Society of Hematology  
1900 M Street, NW, Suite 200  
Washington, DC 20036  
ph 202 776 0544  
fax 202 776 0545  
mliggett@hematology.org

October 11, 2002

American Medical Association  
Dept of CPT Editorial Research and Development  
515 North State Street  
Chicago, IL 60610

Dear Sir/Madam:

As recommended by the AMA RUC at their September 2002 meeting, the American Society of Hematology (ASH) would like to have the phrase "with physician evaluation" added to the definition of CPT 36516 for 2004 (the code is new for 2003). This would change the descriptor to read:

**▲36516 *therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion; with physician evaluation.***

This change is needed to assure that this code is billed only when the physician is present and periodically monitoring the patient during the procedure. The terminology is similar to that already existing for CPT 90935, hemodialysis procedure.

In addition, nine new bone marrow/stem cell processing codes were reviewed by the RUC (CPT codes 38207-38215) and the recommendation made that two of these be revised for 2004 (these are new codes for 2003). Specifically, CPT 38208 and CPT 38209 should change as follows:

**▲38208 *thawing of previously frozen harvest, with washing* ~~thawing of previously frozen harvest~~**

**▲38209 *thawing of previously frozen harvest, without washing* ~~washing of harvest~~**

The rationale for this revision is that bone marrow/stem cell washing is always done with bone marrow/stem cell thawing. However, all harvests that are thawed are not necessarily washed.

Finally, the AMA RUC recommended we petition CPT to add a note to these nine bone marrow/stem cell processing codes (CPT codes 38207-38215) indicating that physicians may not report flow cytometry (CPT codes 88180, 88182, and 88199) separately.

We understand that we do not need to submit a formal CPT application for these changes. If our understanding is not correct, please advise us as soon as possible.

If you have any questions or need additional information at this time, please feel free to contact Mo Mayrides, ASH Director of Policy and Practice, at (202) 292-6005 or at [mmayrides@hematology.org](mailto:mmayrides@hematology.org).

Sincerely,

Samuel M. Silver, MD, PhD  
Chair, ASH Committee on Practice

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

CPT Code: 38207 Tracking Number: X3 Global Period: XXX ~~Recommended RVW: 1.0~~  
RUC Rec. RVW: **0.89**

CPT Descriptor: Cryopreservation and storage

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** Peripheral blood stem cells or bone marrow have been collected. These cells are to be cryopreserved for later use as part of an autologous transplant where hematopoietic progenitor cells have to first be cryopreserved for a later autologous hematopoietic progenitor cell transplant. In many cases, the bone marrow or peripheral blood progenitor cells are also cryopreserved for allogeneic transplants. This ensures that the cells are ready and available when the patient needs them. The physician writes separate prescriptions for cryopreservation and thawing of the product. A physician supervises both cryopreservation and thawing of the product and in an emergency does these procedure himself/herself as a patient life is in jeopardy. The cryopreservation process is begun. It is important to make sure the freezing process is performed correctly to ensure that the cells have been frozen in a safe manner to be acceptable for transplantation. This requires following validated standard operating procedures. Cryopreservation data are reviewed and quality assessment of the procedure is performed. Cells are stored at a low temperature under controlled monitored conditions until needed for transplant. The physician may do this procedure in an emergency. The quality of the cryopreserved transplantation product (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells, allogeneic t-lymphocytes) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells, T-lymphocytes, or tumor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physician then judges if this product remains suitable for transplantation or if new product needs to be collected.

**Description of Pre-Service Work:** Review of donor and patient data.

**Description of Intra-Service Work:** This is basically supervision of the cryopreservation process, review of the freezer curves to make sure they are adequate, review of the CD34 counts, and review of the viability studies to ensure the product is a viable transplant product. A life depends on this evaluation. The FDA requires physician assessment of this procedure and the product processed.

**Description of Post-Service Work:** Preparation of report

**SURVEY DATA:**

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 66% Median RVW: 1.42

Type of Sample (Circle One): random,  panel, convenience. Explanation of sample size:

25th Percentile RVW: 1.23 75th Percentile RVW: 1.88 Low: 1.00 High: 8.00

Median Pre-Service Time: ~~2.5~~ 5 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 56.25 Low: 10 High: 420

Median Post-Service Time:	<u>Total Time</u>	Level of Service by CPT Code (List CPT Code & # of Visits)
---------------------------	-------------------	---

Immediate Post Service Time: 12.5 10

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

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

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

**TIME ESTIMATES (Median)**

	<u>New/Revis. CPT Code:</u>	<u>Key Reference CPT Code:</u>
Median Pre-Time	2.5-5	No RUC data
Median Intra-Time	30	No RUC data
Median Immediate Post-service Time	12.5-10	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.64	3.85
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.93	3.54
Urgency of medical decision making	4.14	3.92

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.29	3.62
Physical effort required	2.43	2.08

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.36	4.00
Outcome depends on the skill and judgement of physician	4.21	4.15
Estimated risk of malpractice suit with poor outcome	4.43	4.38

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Referenc**  
**e Service**  
**1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.13	2.63
Intra-Service intensity/complexity	3.62	3.08
Post-Service intensity/complexity	3.22	2.63

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.  
A panel of physicians from various related societies reviewed the data and reached consensus in developing the recommended work values

---

**FREQUENCY INFORMATION**

How was this service previously reported? 86915 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty \_\_\_\_\_ Frequency: \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty \_\_\_\_\_ Frequency: No Medicare Data on code

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Do many physicians perform this service across the United States? X Yes \_\_\_\_\_ No

---

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

CPT Code: 38208 Tracking Number: X4 Global Period: XXX ~~Recommended RVW: 1.2~~  
RUC Rec. RVW: **0.56**

CPT Descriptor: Thawing of previously frozen harvest

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** The previously cryopreserved marrow and stem cells are thawed in a heated water bath. A sample is obtained for post-thaw quality assessment such as nucleated cell count and viability. Cells are infused immediately post-thaw. The physician may do this procedure in an emergency. The quality of the thawed transplantation product (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells, allogeneic t-lymphocytes) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells, T-lymphocytes, or tumor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physician then judges if this product remains suitable for transplantation or if new product needs to be collected.

**Description of Pre-Service Work:** Review of donor and patient data

**Description of Intra-Service Work:** This is management of a thawing. This usually occurs in front of a physician as the PBSC are put in a water bath and immediately thawed. The process can have failure since the bags break frequently or if the thawing process has failure, there is no graft. The risk to the patient is high because if the thawing process lyses cells, there may be no alternative graft. The FDA requires physician assessment of this procedure and the product processed.

**Description of Post-Service Work:** Preparation of report.

**SURVEY DATA:**

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 76% Median RVW: 1.42

Type of Sample (Circle One): random,  panel, convenience. Explanation of sample size:

25th Percentile RVW: 1.00 75th Percentile RVW: 2.58 Low: 0.37 High: 5

Median Pre-Service Time: 5 Median Intra-Service Time: 45

25th Percentile Intra-Svc Time: 24 75th Percentile Intra-Svc Time: 60 Low: 5 High: 150

Median Post-Service Time: 5 10  
Total Time Level of Service by CPT Code  
(List CPT Code & # of Visits)

Immediate Post Service Time: 5 10

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

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

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

<b><u>TIME ESTIMATES (Median)</u></b>	<b><u>New/Revis. CPT Code:</u></b>	<b><u>Key Reference CPT Code:</u></b>
Median Pre-Time	5	No RUC data
Median Intra-Time	45	No RUC data
Median Immediate Post-service Time	5-10	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.63	3.44
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.31	3.19
Urgency of medical decision making	4.19	3.06

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.88	3.19
Physical effort required	2.56	2.25

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.06	3.19
Outcome depends on the skill and judgement of physician	3.75	3.38
Estimated risk of malpractice suit with poor outcome	4.00	3.31

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference Service**  
**1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.10	2.50
Intra-Service intensity/complexity	3.75	3.13
Post-Service intensity/complexity	3.20	2.50

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.  
A panel of physicians from various related societies reviewed the data and reached consensus on the recommended work value

---

**FREQUENCY INFORMATION**

How was this service previously reported? 86915 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty \_\_\_\_\_ Frequency: \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty \_\_\_\_\_ Frequency: No Medicare Data on code

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

---

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

CPT Code: 38209 Tracking Number: X5 Global Period: XXX ~~Recommended RVW: 0.5~~  
RUC Rec. RVW: **0.24**

CPT Descriptor: Washing of harvest

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** Blood derived hematopoietic progenitor cells have been harvested but the patient mobilizes very poorly with few stem cells. Thus, it is necessary to freeze them in multiple aliquots. Such harvest material contains a significant number of neutrophils or mature granulocytes, which are not capable of restoring hematopoiesis. Only the primitive cells are able to do this. DMSO is necessary for the cryopreservation. Because the cells have been frozen in multiple aliquots (multiple bags of these products were frozen over many days and then thawed later), the total content of DMSO is large and the patient gets a large exposure to DMSO. Such large amounts of DMSO in the transplant can potentially cause projectile vomiting and other injury to the patient. Thus it is necessary to wash the harvest cells to minimize the DMSO content] A physician writes a prescription for this procedure based on the review of the cryopreserved product and whether recipient needs to maximize cell dose or minimize DMSO toxicity. The physician may do this procedure in an emergency.

The thawed cells are washed using an automated cell washer. During the wash process, cells are concentrated and resuspended in infusible grade solutions such as saline/albumin. The physician may do this procedure in an emergency. Quality assessment of the washed product is performed. The quality of the thawed transplantation product (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells, T-lymphocytes, or tumor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physician then judges if this product remains suitable for transplantation or if new or additional product needs to be collected.

**Description of Pre-Service Work:** Review of donor and patient data

**Description of Intra-Service Work:** . This procedure is used when the cell count of the harvest is high due to excessive granulocyte contamination of the progenitor cell harvest. The cell count governs the amount of DMSO used to cryopreserve the cells. DMSO can cause projectile vomiting. This is a washing of immediately thawed stem cells. The washing has to occur over approximately one hour. Since all of these patients would have the thawing intraservice work, the physician effort is incremental to that for the washing. If the washing has a problem the entire graft could be lost and the patient could die. The FDA requires physician assessment of this procedure and the product processed.

**Description of Post-Service Work:** Preparation of report

**SURVEY DATA:**

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 57% Median RVW: 1.25

Type of Sample (Circle One): random,  panel, convenience. Explanation of sample size:

25th Percentile RVW: 0.99 75th Percentile RVW: 2.20 Low: 0.50 High: 4.00

Median Pre-Service Time: 5 Median Intra-Service Time: 37.5

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 60 Low: 0 High: 240

Median Post-Service Time:

Total TimeLevel of Service by CPT Code  
(List CPT Code & # of Visits)

Immediate Post Service Time:

10**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
85097	Bone marrow, smear interpretation	XXX	0.94

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

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

**TIME ESTIMATES (Median)**

<u>New/Revis.</u>	<u>Key Reference</u>
<u>CPT Code:</u>	<u>CPT Code:</u>

Median Pre-Time	5	No RUC data
Median Intra-Time	37.5	No RUC data
Median Immediate Post-service Time	10	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	2.82
Urgency of medical decision making	4.00	3.09

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.92	3.09
Physical effort required	2.42	2.18

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.08	3.36
---	------	------

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

CPT Code: 38209 Tracking Number: X5 Global Period: XXX ~~Recommended RVW: 0.5~~  
RUC Rec. RVW: **0.24**

CPT Descriptor: Washing of harvest

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** Blood derived hematopoietic progenitor cells have been harvested but the patient mobilizes very poorly with few stem cells. Thus, it is necessary to freeze them in multiple aliquots. Such harvest material contains a significant number of neutrophils or mature granulocytes, which are not capable of restoring hematopoiesis. Only the primitive cells are able to do this. DMSO is necessary for the cryopreservation. Because the cells have been frozen in multiple aliquots (multiple bags of these products were frozen over many days and then thawed later), the total content of DMSO is large and the patient gets a large exposure to DMSO. Such large amounts of DMSO in the transplant can potentially cause projectile vomiting and other injury to the patient. Thus it is necessary to wash the harvest cells to minimize the DMSO content] A physician writes a prescription for this procedure based on the review of the cryopreserved product and whether recipient needs to maximize cell dose or minimize DMSO toxicity. The physician may do this procedure in an emergency.

The thawed cells are washed using an automated cell washer. During the wash process, cells are concentrated and resuspended in infusible grade solutions such as saline/albumin. The physician may do this procedure in an emergency. Quality assessment of the washed product is performed. The quality of the thawed transplantation product (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells, T-lymphocytes, or tumor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physician then judges if this product remains suitable for transplantation or if new or additional product needs to be collected.

**Description of Pre-Service Work:** Review of donor and patient data

**Description of Intra-Service Work:** . This procedure is used when the cell count of the harvest is high due to excessive granulocyte contamination of the progenitor cell harvest. The cell count governs the amount of DMSO used to cryopreserve the cells. DMSO can cause projectile vomiting. This is a washing of immediately thawed stem cells. The washing has to occur over approximately one hour. Since all of these patients would have the thawing intraservice work, the physician effort is incremental to that for the washing. If the washing has a problem the entire graft could be lost and the patient could die. The FDA requires physician assessment of this procedure and the product processed.

**Description of Post-Service Work:** Preparation of report

**SURVEY DATA:**

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 57% Median RVW: 1.25

Type of Sample (Circle One): random,  panel, convenience. Explanation of sample size:

25th Percentile RVW: 0.99 75th Percentile RVW: 2.20 Low: 0.50 High: 4.00

Median Pre-Service Time: 5 Median Intra-Service Time: 37.5

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 60 Low: 0 High: 240

Median Post-Service Time:

Level of Service by CPT Code  
(List CPT Code & # of Visits)Total Time

Immediate Post Service Time:

10**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
85097	Bone marrow, smear interpretation	XXX	0.94

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

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

**TIME ESTIMATES (Median)**

<u>New/Revis.</u> <u>CPT Code:</u>	<u>Key Reference</u> <u>CPT Code:</u>
---------------------------------------	--

Median Pre-Time	5	No RUC data
Median Intra-Time	37.5	No RUC data
Median Immediate Post-service Time	10	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	2.82
Urgency of medical decision making	4.00	3.09

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.92	3.09
Physical effort required	2.42	2.18

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.08	3.36
---	------	------

Outcome depends on the skill and judgement of physician	3.50	3.18
---	------	------

Estimated risk of malpractice suit with poor outcome	3.83	3.27
--	------	------

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference Service**  
**1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.33	3.20
----------------------------------	------	------

Intra-Service intensity/complexity	3.55	2.90
------------------------------------	------	------

Post-Service intensity/complexity	3.43	3.17
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

A panel of physicians from various related societies reviewed the data and reached consensus on the recommended work value.

---

**FREQUENCY INFORMATION**

How was this service previously reported? 86915 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty \_\_\_\_\_ Frequency: \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty \_\_\_\_\_ Frequency: No Medicare Data on code

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Do many physicians perform this service across the United States? X Yes \_\_\_\_\_ No

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

CPT Code: 38210 Tracking Number: X6 Global Period: XXX ~~Recommended RVW: 2.0~~  
RUC Rec. RVW: 1.57

CPT Descriptor: Specific cell depletion within harvest; T-cell depletion

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** The typical patient is a 10 year old boy with DiGeorge's Syndrome who needs a bone marrow/peripheral blood progenitor stem cell transplant from his father. The marrow has to be T-cell depleted for this allogeneic graft to reduce the risk of graft versus host disease. The physician writes a prescription ordering this procedure based on recipient needs and the degree of HLA mismatching with the donor. In an emergency the physician may do this procedure.

T-cell depletion is performed using various methods such as the Baxter Isolex device. This instrument enriches the stem cells (CD34+) and passively removes unwanted cells such as T-cells. In an emergency the physician may do this procedure. Quality assessment of the product is performed. The quality of the T-lymphocyte depleted hematopoietic progenitor cell product (bone marrow or blood-derived) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells and T-lymphocytes. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physician then judges if this product remains suitable for transplantation or if new product needs to be collected.

**Description of Pre-Service Work:** Review of donor and patient data

**Description of Intra-Service Work:** Intraservice for this is supervision of the soybean lectin e-rosetting. In allogeneic graft for T-cell depletion this usually occurs in the context of a haploidentical transplant. The work is reviewing the quality control, reviewing the adequacy of the antibodies used, reviewing the adequacy of the soybean lectin. For the use of the isolex or the clinimacs cell selection devices, review of the flow cytometry pre- and post-service. This is probably the most complicated cell processing procedure. The FDA requires physician assessment of this procedure and the product processed.

**Description of Post-Service Work:** Preparation of report.

**SURVEY DATA:**

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 2.50

Type of Sample (Circle One): random,  panel, convenience. Explanation of sample size:

25th Percentile RVW: 1.50 75th Percentile RVW: 3.25 Low: 1.08 High: 10

Median Pre-Service Time: 10 5 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 23 75th Percentile Intra-Svc Time: 210 Low: 0 High: 600

Median Post-Service Time:

Total Time

Level of Service by CPT Code  
(List CPT Code & # of Visits)

Immediate Post Service Time: 20 10

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

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

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

<b><u>TIME ESTIMATES (Median)</u></b>	<b><u>New/Revis. CPT Code:</u></b>	<b><u>Key Reference CPT Code:</u></b>
Median Pre-Time	40-5	No RUC data
Median Intra-Time	60	No RUC data
Median Immediate Post-service Time	20-10	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.13	3.93
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.40	3.47
Urgency of medical decision making	4.40	3.47

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.60	4.14
Physical effort required	2.67	2.21

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.73	3.93
Outcome depends on the skill and judgement of physician	4.47	3.79
Estimated risk of malpractice suit with poor outcome	4.27	3.79

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference Service**  
**1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.20	2.89
Intra-Service intensity/complexity	4.21	3.47
Post-Service intensity/complexity	3.70	2.80

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.  
A panel of physicians from various related societies reviewed the data and reached consensus on the recommended work value

---

**FREQUENCY INFORMATION**

How was this service previously reported? 86915 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty \_\_\_\_\_ Frequency: \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty \_\_\_\_\_ Frequency: No Medicare Data on code

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Do many physicians perform this service across the United States? X Yes \_\_\_\_\_ No

---

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

CPT Code: 38211 Tracking Number: X7 Global Period: XXX ~~Recommended RVW: 1.5~~  
RUC Rec. RVW: **1.42**

CPT Descriptor: Tumor Cell Depletion

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** The typical patient is a 25 year old male with B-cell lymphoma or breast cancer metastatic to the bone marrow. The patient needs an autologous peripheral blood stem cell harvest with later transplant but there is known tumor contamination in the bone marrow. A physician writes a prescription for this procedure based on review of the patient's disease and risk of tumor contamination. In an emergency, a physician may do this procedure.

Tumor cell depletion is performed using various methods such as the Baxter Isolex device, which has been FDA approved for tumor depletion. The instrument enriches for stem cells (CD34+) and passively removes unwanted cells such as tumor cells. Quality assessment of the product is performed. In an emergency a physician may do this procedure. The quality of the tumor cell depleted hematopoietic progenitor cell product (bone marrow or blood-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells and or tumor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physician then judges if this product remains suitable for transplantation or if new product needs to be collected.

**Description of Pre-Service Work:** Review of donor and patient data

**Description of Intra-Service Work:** Intraservice is for patients with stem cells or marrow contaminated with tumor cells either B-cell lymphoma or breast cancer. The FDA approved machine is the isolex device. The supervision of a processing plus validation of the quality control and the adequacy of the stem cell product, that there is sufficient product for transplantation. Failure to do this increases the patient's risk of relapse. This procedure is slightly less complicated than the T-cell depletion. The FDA requires physician assessment of this procedure and the product processed.

**Description of Post-Service Work:** Preparation of report

**SURVEY DATA:**

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 2.27

Type of Sample (Circle One): random,  panel, convenience. Explanation of sample size:

25th Percentile RVW: 1.63 75th Percentile RVW: 2.75 Low: 1.00 High: 6.00

Median Pre-Service Time: 5 Median Intra-Service Time: 60

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 105 Low: 0 High: 360

Median Post-Service Time:

<u>Total Time</u>	<u>Level of Service by CPT Code</u> <u>(List CPT Code &amp; # of Visits)</u>
-------------------	---

Immediate Post Service Time:	<u>10</u>
------------------------------	-----------

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

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

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

**TIME ESTIMATES (Median)**

	<b>New/Revis. CPT Code:</b>	<b>Key Reference CPT Code:</b>
Median Pre-Time	5	No RUC data
Median Intra-Time	60	No RUC data
Median Immediate Post-service Time	10	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.80	3.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	3.36
Urgency of medical decision making	4.07	3.21

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.57	4.00
Physical effort required	2.57	2.15

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.13	3.86
Outcome depends on the skill and judgement of physician	3.93	3.57
Estimated risk of malpractice suit with poor outcome	3.80	3.79

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference Service**  
**1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	2.90	2.60
Intra-Service intensity/complexity	4.14	3.47
Post-Service intensity/complexity	3.50	2.80

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.  
A panel of physicians from various related societies reviewed and reached consensus on the recommended work value.

**FREQUENCY INFORMATION**

How was this service previously reported? 86915 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty \_\_\_\_\_ Frequency: \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty \_\_\_\_\_ Frequency: No Medicare Data on code

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Do many physicians perform this service across the United States? X Yes \_\_\_\_\_ No

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

CPT Code: 38212 Tracking Number: X8 Global Period: XXX ~~Recommended RVW: 1.0~~  
RUC Rec. RVW: **0.94**

CPT Descriptor: Red blood cell removal

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** A 35 year old female with leukemia is blood type O and requires a peripheral blood stem cell transplant. The donor is blood type A. With such a stem cell harvest, ABO blood group barriers are routinely crossed. If fresh bone marrow containing Type A red blood cells is given to the patient, those type A cells will be immediately hemolyzed. This would cause renal failure and ultimately death to the patient because they could not receive post transplant immunosuppression therapy. Because of the different blood types, red blood cell depletion is required from the harvest. The stem cell harvest is then performed. A physician writes an order for this procedure and supervises it. In an emergency, a physician may do this procedure.

The red cell depletion can be done by various methods such as mononuclear cell concentration using an FDA approved apheresis device, mononuclear cell enrichment using density gradient solution, hydroxyethyl starch which is FDA approved as an infusible solution. In an emergency a physician may do this procedure. Quality assessment of the product is performed. The quality of the hematopoietic progenitor cells (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are hematocrit, red cell count, nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physician then judges if this product remains suitable for transplantation or if new product needs to be collected.

**Description of Pre-Service Work:** Review of donor and patient data

**Description of Intra-Service Work:** This procedure is done when there is major ABO incompatibility. This is a removal of red cells from the product. This is done by hetastart separation. It takes approximately 50 minutes. The physician would ensure there is an adequate CD34 count post-selection and there is minimal red cell contamination. Failure to properly assess red blood cell removal will cause an acute hemolysis with infusion of the graft. The FDA requires physician assessment of this procedure and the product processed.

**Description of Post-Service Work:** Preparation of report.

**SURVEY DATA:**

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 1.50

Type of Sample (Circle One): random,  panel, convenience. Explanation of sample size:

25th Percentile RVW: 1.00 75th Percentile RVW: 2.10 Low: 0.50 High: 3.00

Median Pre-Service Time: 5 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 12.5 75th Percentile Intra-Svc Time: 120 Low: 0 High: 150

Median Post-Service Time:	<u>Total Time</u>	Level of Service by CPT Code (List CPT Code & # of Visits)
---------------------------	-------------------	---

Immediate Post Service Time:	<u>15- 10</u>
------------------------------	---------------

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
90935	Hemodialysis procedure with single physician evaluation	000	1.22

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

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

**TIME ESTIMATES (Median)**

	<b>New/Revis. CPT Code:</b>	<b>Key Reference CPT Code:</b>
Median Pre-Time	5	0
Median Intra-Time	30	21
Median Immediate Post-service Time	15-10	0
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.33	3.53
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.20	3.00
Urgency of medical decision making	3.60	3.20

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.80	3.53
Physical effort required	2.27	2.40

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.07	4.07
Outcome depends on the skill and judgement of physician	3.80	3.67
Estimated risk of malpractice suit with poor outcome	4.33	3.47

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference Service**  
**1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	2.70	2.70
Intra-Service intensity/complexity	3.50	3.27
Post-Service intensity/complexity	3.40	2.80

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.  
A panel of physicians from various related societies reviewed the data and reached consensus on the recommended work value.

---

**FREQUENCY INFORMATION**

How was this service previously reported? 86915 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty \_\_\_\_\_ Frequency: \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty \_\_\_\_\_ Frequency: No Medicare Data on code

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Do many physicians perform this service across the United States? X Yes \_\_\_\_\_ No

---

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

CPT Code: 38213 Tracking Number: X9 Global Period: XXX ~~Recommended RVW: 0.5~~  
RUC Rec. RVW: **0.24**

CPT Descriptor: Platelet depletion

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** The typical patient is a 35 year old female with leukemia who requires an allogeneic peripheral blood stem cell transplant. The donor is much smaller than the intended recipient, thus requiring multiple days of harvesting. Because multiple successive days of stem cell collection causes the donor's platelets to become severely depleted, prior platelet depletion of the donor is required. The physician assesses both donor needs and recipient needs as this procedure will deplete some of the hematopoietic progenitors collected. A physician writes a prescription for a platelet addback to be obtained and separated from the blood-derived hematopoietic progenitor cell product. A physician supervises this procedure. In an emergency a physician does this procedure. The collected apheresis product is depleted of platelets using a centrifugation method. The separated platelets are infused back to the donor and the stem cells are used for transplantation for the patient. In an emergency a physician does this procedure. Quality assessment on both products is performed. It is critical to be sure that the donor is not harmed by an excessively low platelet count as part of the transplant process. The physician has to ascertain whether there is a quality platelet product obtained from the donor with minimal risk to the transplant product. . The quality of the platelets (bone marrow or blood-derived) must be assessed prior to release of product. Examples of quality assurance are platelet count, hematocrit, nucleated cell count, viability, and sterility. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physician then judges if this product is suitable for infusion.

**Description of Pre-Service Work:** Review of donor and patient data

**Description of Intra-Service Work:** This is basically done via a cell selector such as the Cobe Spectra for removal of platelets from a stem cell collection. There will be loss of stem cells. The platelets will be infused in recipients. The FDA requires physician assessment of this procedure and the product processed.

**Description of Post-Service Work:** Preparation of report

**SURVEY DATA:**

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 52% Median RVW: 1.20

Type of Sample (Circle One): random,  panel, convenience. Explanation of sample size:

25th Percentile RVW: 1.00 75th Percentile RVW: 1.75 Low: 0.80 High: 3.50

Median Pre-Service Time: 40-5 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 20 75th Percentile Intra-Svc Time: 67.5 Low: 0 High: 180

Median Post-Service Time:

Total Time

Level of Service by CPT Code  
(List CPT Code & # of Visits)

Immediate Post Service Time: 10

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

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

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

**TIME ESTIMATES (Median)**

	<b>New/Revis. CPT Code:</b>	<b>Key Reference CPT Code:</b>
Median Pre-Time	40 5	No RUC data
Median Intra-Time	30	No RUC data
Median Immediate Post-service Time	10	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.27	3.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.18	3.73
Urgency of medical decision making	3.91	3.73

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	3.82
Physical effort required	2.55	2.82

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.00	3.82
Outcome depends on the skill and judgement of physician	3.55	3.73
Estimated risk of malpractice suit with poor outcome	4.00	3.45

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Referenc  
**e Service**  
**1******Time Segments (Mean)**

Pre-Service intensity/complexity	3.33	3.17
Intra-Service intensity/complexity	3.30	3.45
Post-Service intensity/complexity	3.33	3.00

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

A panel of physicians from various related societies reviewed the data and reached consensus on the recommended work value.

---

**FREQUENCY INFORMATION**

How was this service previously reported? 86915 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty \_\_\_\_\_ Frequency: \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty \_\_\_\_\_ Frequency: No Medicare Data on code

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Do many physicians perform this service across the United States? X Yes \_\_\_\_\_ No

---

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

CPT Code: 38214 Tracking Number: X10 Global Period: XXX ~~Recommended RVW: 0.50~~  
RUC Rec. RVW: **0.81**

CPT Descriptor: Plasma (volume) depletion

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** The typical patient is a 35 year old female with leukemia who is type A and requires a bone marrow transplant. The only available donor is type O. The donor's type O plasma has sufficient anti-A that it may cause hemolysis with infusion of the marrow product. The plasma needs to be depleted from this product so that there can be a safe transplant. A physician writes a prescription for and supervises this procedure. In an emergency a physician does this procedure.

Plasma/volume depletion can be done by various methods (i.e. centrifugation or nucleated cell concentration using an FDA approved apheresis device. In this process, stem cells are concentrated and plasma/excess volume are removed. In an emergency a physician does this procedure. Quality assessment of the product is performed. The quality of the plasma depleted hematopoietic progenitor cell transplantation product (bone marrow-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells or T-lymphocytes. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physician then judges if this product remains suitable for transplantation or if the procedure needs to be repeated.

**Description of Pre-Service Work:** Review of donor and patient data

**Description of Intra-Service Work:** This is when there is minor ABO incompatibility to prevent hemolysis of the recipient's red cells by plasma depletion. This is usually done by density gradient. The FDA requires physician assessment of this procedure and the product processed.

**Description of Post-Service Work:** Preparation of report.

**SURVEY DATA:**

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 1.30

Type of Sample (Circle One): random,  panel, convenience. Explanation of sample size:

25th Percentile RVW: 1.00 75th Percentile RVW: 1.66 Low: 0.50 High: 2.80

Median Pre-Service Time: 5 Median Intra-Service Time: 30

25th Percentile Intra-Svc Time: 10 75th Percentile Intra-Svc Time: 60 Low: 0 High: 120

Median Post-Service Time:	<u>5</u>	Level of Service by CPT Code
	<u>10</u>	(List CPT Code & # of Visits)

Immediate Post Service Time: 5 10

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

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

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

<b><u>TIME ESTIMATES (Median)</u></b>	<b><u>New/Revis. CPT Code:</u></b>	<b><u>Key Reference CPT Code:</u></b>
Median Pre-Time	5	No RUC data
Median Intra-Time	30	No RUC data
Median Immediate Post-service Time	5-10	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.27	3.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.13
Urgency of medical decision making	3.73	3.07

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.80	3.67
Physical effort required	2.20	2.27

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.13	3.93
Outcome depends on the skill and judgement of physician	3.67	3.60
Estimated risk of malpractice suit with poor outcome	4.07	3.60

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference Service**  
**1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	2.70	2.60
Intra-Service intensity/complexity	3.36	3.27
Post-Service intensity/complexity	3.22	2.78

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.  
A panel of physicians from various related societies reviewed the data and reached consensus on the recommended work value

---

**FREQUENCY INFORMATION**

How was this service previously reported? 86915 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty \_\_\_\_\_ Frequency: \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty \_\_\_\_\_ Frequency: No Medicare Data on code

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Do many physicians perform this service across the United States? X Yes \_\_\_\_\_ No

---

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

CPT Code: 38215 Tracking Number: X11 Global Period: XXX ~~Recommended RVW: 1.18~~  
RUC Rec. RVW: **0.94**

CPT Descriptor: Cell concentration in plasma, mononuclear, or buffy coat layer

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** The typical patient is a 35 year old female with leukemia who is type B and requires a peripheral blood stem cell transplant. The only available donor is type A. Thus, to prevent transplant problems, a purified hematopoietic progenitor cell population (with minimal red cell and plasma contamination) is needed for the graft. A physician writes an order for this procedure and supervises. In an emergency a physician may do this procedure.

In this scenario, to avoid hemolytic transfusion reaction, both the RBCs and plasma must be removed. This can be achieved by various methods such as mononuclear cell concentration using an FDA approved apheresis device or density gradients solutions. In this process, stem cells are concentrated and plasma/excess volumes are removed. In an emergency a physician may do this procedure. Quality assessment of the product is performed. The quality of the mononuclear cell preparation of the hematopoietic progenitor cell transplantation product (bone marrow, blood-derived, or umbilical cord blood-derived hematopoietic progenitor cells) must be assessed prior to release of product. Examples of quality assurance are hematocrit, nucleated cell count, differential, viability, sterility and/or immunophenotyping by flow cytometry for cd34(+) progenitor cells and T-lymphocytes. These parameters are recognized by two accreditation agencies (FAHCT and AABB) as necessary and are included in the regulations recently proposed by the FDA. The physician then judges if this product remains suitable for transplantation or if the procedure needs to be repeated or if new product needs to be collected.

**Description of Pre-Service Work:** Review of donor and patient data

**Description of Intra-Service Work:** This procedure is performed for major/minor ABO incompatibility of the graft or when one standard red cell depletion has not removed all the potential red cells that have caused an acute reaction. This procedure's failure will either cause graft failure or acute hemolysis with graft infusion. Risk to the patient is quite high. Both risk and loss of graft in the allogeneic setting is high because this procedure has a great deal of stem cell loss. The FDA requires physician assessment of this procedure and the product processed.

**Description of Post-Service Work:** Preparation of report

**SURVEY DATA:**

Presenter(s) Drs. James Gajewski and Sam Silver

Specialty(s): American Society for Hematology and American Society for Blood and Marrow Transplantation

Sample Size: 21 Response Rate: (%): 71% Median RVW: 1.50

Type of Sample (Circle One): random,  panel, convenience. Explanation of sample size:

25th Percentile RVW: 1.18 75th Percentile RVW: 1.99 Low: 0.50 High: 3.60

Median Pre-Service Time: 5 Median Intra-Service Time: 40

25th Percentile Intra-Svc Time: 25 75th Percentile Intra-Svc Time: 110 Low: 0 High: 150

Median Post-Service Time: \_\_\_\_\_  
Total Time \_\_\_\_\_ Level of Service by CPT Code  
(List CPT Code & # of Visits)

Immediate Post Service Time: 45- 10

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records	XXX	1.33

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

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

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revis. CPT Code:</u>	<u>Key Reference CPT Code:</u>
Median Pre-Time	5	No RUC data
Median Intra-Time	40	No RUC data
Median Immediate Post-service Time	15 10	No RUC data
Median of Aggregate Critical Care Times		
Median of Aggregate Other Hospital Visit Times		
Median Discharge Day Management Time		
Median of Aggregate Office Visit Times		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.47	3.47
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.73	3.27
Urgency of medical decision making	4.00	3.53

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.20	3.80
Physical effort required	2.53	2.27

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.40	4.33
Outcome depends on the skill and judgement of physician	4.20	3.93
Estimated risk of malpractice suit with poor outcome	4.20	3.93

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference Service**  
**1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	2.70	2.60
Intra-Service intensity/complexity	3.64	3.20
Post-Service intensity/complexity	3.20	2.60

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.  
A panel of physicians from various related societies reviewed the data and reached consensus on the recommended work value.

---

**FREQUENCY INFORMATION**

How was this service previously reported? 86915 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty \_\_\_\_\_ Frequency: \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty \_\_\_\_\_ Frequency: No Medicare Data on code

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Do many physicians perform this service across the United States? X Yes \_\_\_\_\_ No

---

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2002/September 2002

**Excision of Mandible/Facial Bone Tumor**

Two revised CPT codes (21030 and 21040) were re-reviewed by the RUC in September 2002. Previously, the RUC reviewed four new codes in this family and made recommendations to the Center's for Medicare and Medicaid in May 2002. The four new codes (21046, 21047, 21048 and 21049) were developed to reflect the increased intra-operative time, the extent of surgery and the increased intensity level required to perform these services as compared to the codes currently being used, which inadequately describe the intensity of the procedures being performed.

**Codes 21030 and 21040**

In April 2002, the RUC reviewed codes 21030 *Excision of benign tumor or cyst of ~~facial bone other than mandible, maxilla or zygoma, by enucleation and curettage~~* and 21040 *Excision of ~~benign cyst or tumor, tumor or cyst of mandible, by enucleation and curettage simple~~*. The RUC decided to table these codes pending review of the CPT panel to clarify some language issues and the possible re-surveying of these codes by the specialty societies pending the CPT decision. The CPT Editorial Panel did review these codes in May 2002 and modified the codes to state "enucleation and/or curettage."

At the September 2002 meeting, the RUC reviewed survey data obtained by the specialty society. The reference CPT code 21555, *Excision tumor, soft tissue of neck or thorax; subcutaneous*, was selected by the survey respondents as having similar total work (work RVU= 4.35), and is comparable to the survey median RUV for CPT code 21030 and the 25<sup>th</sup> percentile for CPT code 21040. In addition, IWPUT analysis demonstrated that the RVU for of 4.50 is reasonable for both codes. The survey time for codes 21030 and 21040, 30 minutes pre-service time, 33/37 minutes, respectively, intra-service time, and 15 minutes post-service time, is similar to the Harvard time for 21555 (27 minutes pre-service time, 41 minutes intra-service time, and 10- minutes post-service time). Further, the total RVU for these two codes is less than budget neutral, and therefore is appropriate. CPT code 21030 had previously been valued at 6.46 with 10,330 claims and 21040 had previously been valued at 2.11 with 2,342 claims. **The RUC recommends a work relative value of 4.50 for CPT codes 21030 and 21040.**

**Previously Approved RUC Recommendations**

**Code 21034**

The work RVU for code 21034, *Excision of malignant tumor of maxilla or zygoma*, was not revised by the RUC, as the RUC viewed the CPT changes to be editorial in nature.

### **Codes 21046 and 21048**

The RUC examined codes 21046 *Excision of benign tumor or cyst, mandible; with intra-oral osteotomy (eg, locally aggressive or destructive lesion* and 21048 *Excision of benign tumor or cyst of maxilla, requiring intra-oral osteotomy (eg locally aggressive or destructive lesion(s))*. The RUC agreed with the specialty societies' recommendations that these codes were needed to describe the intensity level of the service being performed. The RUC also agreed that the recommended relative work value for 21046 and 21048, both the survey medians, were appropriate. Both of these services are comparable in work to CPT code 21206 *Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)* (work RVU = 14.10 with a pre-service time of 75 minutes, intra-service time of 108 minutes post-service time of 57 minutes, post-op hospital time of 41 minutes and post-op office visit time of 95 minutes. Code 21046 and 21048 both had survey time of 75 minutes for pre-service, 120 minutes of intra-service, 30 minutes of post-service 1 hospital visit, discharge day and 5 office visits. The survey respondents did indicate that 21048 was more intense than 21046, therefore an incremental increase is appropriate. **The RUC recommends a work relative value of 13.00 for 21046 and 13.50 for 21048.**

### **Code 21047**

The RUC considered the specialty societies' recommendation for code 21047 *Excision of benign tumor or cyst, mandible; with extra-oral osteotomy and partial mandibulectomy (eg locally aggressive or destructive lesion)*. The RUC compared the work of 21047 to 21046 and agreed that the additional 120 minutes of intra-service work justified the increment of 5.75 over the base code. **The RUC recommends a work relative value of 18.75 for 21047.**

### **Code 21049**

The RUC assessed the specialty societies' recommendation for code 21049 *Excision of benign tumor or cyst, maxilla; with extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion)*. Because of the aggressive nature of the ameloblastic fibro-odontoma, which requires radical excision to obliterate them and prevent re-occurrence, the RUC agreed with the intensity of this service. Additional justification for this recommendation included the increased intensity associated with the extra-oral approach and the higher surveyed intensity as compared to the reference code 21206 *Osteotomy, maxilla, segmental (eg Wassmund or Schuchard)* (RVU = 14.10). In addition, the total time for the surveyed code (543 minutes) far exceeded that of the reference code (348 minutes). **The RUC recommends a work relative value of 18.00 for 21049.**

### **Practice Expense**

The RUC reviewed the practice expense inputs for 21046-49 and recommends that the standard 90-day global package would be applied to all of these codes. For CPT codes 21030 and 21040, the RUC eliminated the one half 99238 discharge visit, (6 minutes) for the clinical staff time, as this service is typically performed in an office setting. All other inputs were approved.

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
σ21030	F1	Excision of benign tumor or cyst of <del>facial bone</del> <del>other than mandible, maxilla or zygoma, by</del> <u>enucleation and curettage</u>	090	4.50
σ21034	F2	Excision of malignant tumor of <del>facial bone, other</del> <del>than mandible</del> <u>maxilla or zygoma</u>	090	16.17 (no change)
σ21040	F3	Excision of <del>benign cyst or tumor, tumor or cyst</del> of mandible; <u>by enucleation and/or curettage</u> simple	090	4.50
21041(D)		<del>complex</del>  <u>21041 has been deleted. To report, see 210X1 or</u> <u>210X2)</u>	090	N/A
●21046	F4	Excision of benign tumor or cyst of mandible; with intraoral osteotomy (eg, locally aggressive or destructive lesion(s))	090	13.00 (RUC Recommendation to CMS May 2002)
●21047	F5	requiring extra-oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion(s))	090	18.75 (RUC Recommendation to CMS May 2002)
●21048	F6	Excision of benign tumor or cyst of maxilla;	090	13.50 (RUC

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

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
		requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s))		Recommendation to CMS May 2002)
●21049	F7	requiring extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion(s))	090	18.00 (RUC Recommendation to CMS May 2002)

CPT Code: 21030 (F1)

Global: 090

Recommended RVW: 4.50

CPT Descriptor: Excision of benign tumor or cyst of ~~facial bone other than mandible,~~ maxilla or zygoma, by enucleation and curettage

---

**Survey Vignette (Typical Patient)**

A 22-year-old female has a pear-shaped radiolucent area between her left lateral and cuspid teeth. Previous evaluation, both clinically and radiographically, has determined that this is most likely a classic globulomaxillary cyst, producing typical divergence of the roots of these vital teeth. Under local anesthesia, the lesion is approached with an appropriate incision and elevation of a mucoperiosteal flap. The lesion is removed via enucleation and curettage and the area is irrigated and the flap returned and sutured. Postoperative office visits are conducted as necessary through the 90-day global period for suture removal, review of pathology report, and review of radiographs to monitor defect correction and the health of the affected teeth. [When completing this survey please consider only the preservice work within 24 hours of the procedure, the procedure itself, and all work through the 90-day global period. You may continue to see the patient beyond the 90-day global period, but that work would be separately reportable.]

---

**CLINICAL DESCRIPTION OF SERVICE:**

**PREOPERATIVE WORK:**

- Review pre-operative work-up, including all radiographs
- Review planned incisions and procedure
- Answer patient and family questions and obtain informed consent

**INTRA-SERVICE WORK:**

Under local anesthesia, an incision is made and a mucoperiosteal flap raised. The lesion is removed via enucleation and curettage and sent for pathological diagnosis. The area is irrigated and the flap returned and sutured.

**POSTOPERATIVE WORK, DAY OF PROCEDURE:**

- Answer patient/family questions
- Dictate post-op report
- Review instructions for post-discharge wound care and home care with patient and family
- Write orders for medications

**POSTOPERATIVE WORK, FOLLOWUP OFFICE VISITS:**

- Examine and talk with patient
  - Check wounds
  - Review pathology report with patient/family
  - Order and review radiographs to monitor defect correction and the health of the affected teeth
  - Answer patient/family questions
  - Answer insurance staff questions
  - Write orders for medications
-

**SURVEY DATA**

<b>Presenter(s):</b>	Lanny Garvar, DMD				
<b>Specialty(s):</b>	American Association of Oral & Maxillofacial Surgeons/American Dental Association				
<b>CPT Code:</b>	21030				
<b>Sample Size:</b>	125	<b>Resp n:</b>	32	<b>Resp %:</b>	26%
<b>Sample Type:</b>	Random				
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		3.00	4.22	4.50	5.90
<b>Pre-Service Time:</b>				30	
<b>Intra-Service Time:</b>		20	30	33	45
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<i>Day of Surgery:</i>					
<b>Immed. Post-time:</b>	15				
<b>Other Post-time/visit:</b>	0				
<i>After Day of Surgery:</i>					
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	0				
<b>Office time/visit(s):</b>	53	99213 x 1 ; 99212 x 2			

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'02RVW	Glob
21555	Excision tumor, soft tissue of neck or thorax; subcutaneous	4.35	090

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

<b>TIME ESTIMATES (MEDIAN)</b>	<b>Svy CPT 21040</b>	<b>Ref CPT (Hvd)</b>
Pre-service time	30	27
Intra-service time	33	41
Same Day Immediate Post-service time	15	10
Same Day Other Post-service time	0	0
Post Total critical care time (not same day)	0	0
Post Total other hospital visit time (not same day)	0	0
Discharge management time	0	11
Total office visit time	53	42

*Total Time*    130            131

**INTENSITY/COMPLEXITY MEASURES (mean)**

<b>TIME SEGMENTS</b>	<b>Svy CPT 21030</b>	<b>Ref CPT (Hvd)</b>
Pre-service	2.67	2.67
Intra-service	2.33	2.56
Post-service	2.33	2.33
<b>MENTAL EFFORT AND JUDGMENT</b>		
The number of possible diagnosis and/or the number of management options that must be considered	2.44	2.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.44	2.67
Urgency of medical decision making	1.89	2.22
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>		
Technical skill required	2.44	2.56
Physical effort required	2.22	2.33
<b>PSYCHOLOGICAL STRESS</b>		
The risk of significant complications, morbidity and/or mortality	1.89	2.11
Outcome depends on the skill and judgment of physician	2.22	2.44
Estimated risk of malpractice suit with poor outcome	2.33	2.56

**RATIONALE:**

The total time for codes 21030 and 21040 shown in the RUC database represent a CMS-based proxy ("pr") for use in calculating practice expense pools and have no survey basis. Codes 21030 and 21040 have been revised, along with other new/revised/deleted codes in the family of "excision of mandible/facial bone tumor" to more clearly differentiate 'simple versus complex' and 'non-aggressive versus aggressive' lesions.

Codes 21030 and 21040, as revised, represent similar procedures, differentiated only by the lesion location (maxilla/zygoma versus mandible). The current RVWs for 21030 and 21040 are 6.46 and 2.11 respectively. Because these codes have been revised (along with other codes in the family, previously reviewed by the RUC), and because the current RVWs do not make sense and are not based on surveys, the AAOMS conducted surveys to obtain survey-based RVWs for these revised codes, supported by time and visit data.

With respect to the reference code 21555, these codes reflect similar total work.

As stated above, these codes represent similar procedures and the survey times and visit data are almost identical. Therefore, we are recommending an RVW of 4.50 for both codes 21030 (median) and 21040 (25<sup>th</sup> percentile).

The IWPUT analysis below shows that an RVW of 4.50 for both codes is reasonable.

Further, the total RVU's for these two codes is less than budget neutral:

<b>CPT</b>	<b>2000 Freq</b>	<b>2002 RVW</b>	<b>Current RVUs</b>	<b>Recom'd. RVW</b>	<b>Estimated RVUs</b>
21030	1,599	6.46	10,330	4.50	7,196
21040	1,110	2.11	2,342	4.50	4,995
<b>Total</b>			<b>12,672</b>		<b>12,191</b>

IWPUT ANALYSIS		Survey CPT code: 21030			Survey CPT code: 21040		
Row	Column	A	B	C	D	E	F
1				MEDIAN Svy RVW: <u>4.50</u>			25 <sup>th</sup> Pctl Svy RVW: <u>4.50</u>
2		Survey Data		RVW	Survey Data		RVW
3	Pre-service	Time	Intensity	(=time x intensity)	Time	Intensity	(=time x intensity)
4	Pre-service	30	0.0224	0.67	30	0.0224	0.67
6	PRE-service total:			<u>0.67</u>			<u>0.67</u>
7	Post-service	Time	Intensity	(=time x intensity)	Time	Intensity	(=time x intensity)
8	Immediate post	15	0.0224	0.34	15	0.0224	0.34
9	Subsequent visits:	Visit n	E/M RVW	(=n x RVW)	Visit n	E/M RVW	(=n x RVW)
19	99215	0	1.73**	0	0	1.73**	0
20	99214	0	1.08**	0	0	1.08**	0
21	99213	1	0.65**	0.65	1	0.65**	0.65
22	99212	2	0.43**	0.86	2	0.43**	0.86
23	99211	0	0.17**	0	0	0.17**	0
24	POST-service total:			<u>1.85</u>			<u>1.85</u>
25		Time	IWPUT	INTRA-RVW	Time	IWPUT	INTRA-RVW
26	INTRA-SERVICE:	33	0.060	<u>1.98</u>	37	0.054	<u>1.98</u>

\*\*Note: Office visit RVW's shown reflect RUC/CMS "discounted" values.

**FREQUENCY INFORMATION**

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

21030 (with and without mod -22) Excision of benign tumor or cyst of facial bone other than mandible

2. How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: maxillofacial surgery, oral surgery      Commonly      Sometimes      Rarely

3. For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: maxillofacial surgery, oral surgery      Frequency: 3,000

4. For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty: maxillofacial surgery, oral surgery      Frequency: 1,600

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Many physicians would be able to perform this procedure, if necessary.

CPT Code: 21040 (F3)

Global: 090

Recommended RVW: 4.50

CPT Descriptor: Excision of benign cyst or tumor, tumor or cyst of mandible; by enucleation and curettage simple

---

**Survey Vignette (Typical Patient)**

An 18-year-old male has a painless swelling over the right posterior body of the mandible. Previous evaluation, both clinically and radiographically, has determined that this is most likely a traumatic bone cyst. The lesion runs from the second bicuspid to the second molar. Under local anesthesia, an incision is made and a mucoperiosteal flap raised. The lining is composed of a thin fibrous membrane which is curetted and the area is irrigated and the flap returned and sutured. Postoperative office visits are conducted as necessary through the 90-day global period for suture removal, review of pathology report, and review of radiographs to monitor defect correction and the health of the affected teeth. [When completing this survey please consider only the preservice work within 24 hours of the procedure, the procedure itself, and all work through the 90-day global period. You may continue to see the patient beyond the 90-day global period, but that work would be separately reportable.]

---

**CLINICAL DESCRIPTION OF SERVICE:**

**PREOPERATIVE WORK:**

- Review pre-operative work-up, including all radiographs
- Review planned incisions and procedure
- Answer patient and family questions and obtain informed consent

**INTRA-SERVICE WORK:**

Under local anesthesia, an incision is made and a mucoperiosteal flap raised. Once the defect is entered, it is noted to be an empty cavity with no fluid or solid material. The lining is composed of a thin fibrous membrane, which is curetted and sent for pathologic diagnosis. The cavity is irrigated and the flap returned and sutured.

**POSTOPERATIVE WORK, DAY OF PROCEDURE:**

- Answer patient/family questions
- Dictate post-op report
- Review instructions for post-discharge wound care and home care with patient and family
- Write orders for medications

**POSTOPERATIVE WORK, FOLLOWUP OFFICE VISITS:**

- Examine and talk with patient
  - Check wounds
  - Review pathology report with patient/family
  - Order and review radiographs to monitor defect correction and the health of the affected teeth
  - Answer patient/family questions
  - Answer insurance staff questions
  - Write orders for medications
-

**SURVEY DATA**

<b>Presenter(s):</b>		Lanny Garvar, DMD			
<b>Specialty(s):</b>		American Association of Oral & Maxillofacial Surgeons/American Dental Association			
<b>CPT Code:</b>		21040			
<b>Sample Size:</b>	125	<b>Resp n:</b>	32	<b>Resp %:</b>	26%
<b>Sample Type:</b>		Random			
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		3.10	4.50	6.00	7.20
<b>Pre-Service Time:</b>				30	
<b>Intra-Service Time:</b>		15	30	37	45
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<i>Day of Surgery:</i>					
<b>Immed. Post-time:</b>	15				
<b>Other Post-time/visit:</b>	0				
<i>After Day of Surgery:</i>					
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	0				
<b>Discharge Day Mgmt:</b>	0				
<b>Office time/visit(s):</b>	53	99213 x 1 ; 99212 x 2			

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'02RVW	Glob
21555	Excision tumor, soft tissue of neck or thorax; subcutaneous	4.35	090

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

<b>TIME ESTIMATES (MEDIAN)</b>	<b>Svy CPT 21040</b>	<b>Ref CPT (Hvd)</b>
Pre-service time	30	27
Intra-service time	37	41
Same Day Immediate Post-service time	15	10
Same Day Other Post-service time	0	0
Post Total critical care time (not same day)	0	0
Post Total other hospital visit time (not same day)	0	0
Discharge management time	0	11
Total office visit time	53	42

*Total Time*      135              131

**INTENSITY/COMPLEXITY MEASURES (mean)**

<b>TIME SEGMENTS</b>	<b>Svy CPT 21040</b>	<b>Ref CPT (Hvd)</b>
Pre-service	2.13	2.11
Intra-service	2.13	2.11
Post-service	2.00	2.00
<b>MENTAL EFFORT AND JUDGMENT</b>		
The number of possible diagnosis and/or the number of management options that must be considered	2.44	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.33	2.11
Urgency of medical decision making	1.78	1.89
<b>TECHNICAL SKILL/PHYSICAL EFFORT</b>		
Technical skill required	2.44	2.11
Physical effort required	2.22	2.11
<b>PSYCHOLOGICAL STRESS</b>		
The risk of significant complications, morbidity and/or mortality	1.78	1.67
Outcome depends on the skill and judgment of physician	2.00	2.00
Estimated risk of malpractice suit with poor outcome	2.22	1.89

**RATIONALE:**

The total time for codes 21030 and 21040 shown in the RUC database represent a CMS-based proxy ("pr") for use in calculating practice expense pools and have no survey basis. Codes 21030 and 21040 have been revised, along with other new/revised/deleted codes in the family of "excision of mandible/facial bone tumor" to more clearly differentiate 'simple versus complex' and 'non-aggressive versus aggressive' lesions.

Codes 21030 and 21040, as revised, represent similar procedures, differentiated only by the lesion location (maxilla/zygoma versus mandible). The current RVWs for 21030 and 21040 are 6.46 and 2.11 respectively. Because these codes have been revised (along with other codes in the family, previously review by the RUC), and because the current RVWs do not make sense and are not based on surveys, the AAOMS conducted surveys to obtain survey-based RVWs for these revised codes, supported by time and visit data.

With respect to the reference code 21555, these codes reflect similar total work.

As stated above, these codes represent similar procedures and the survey times and visit data are almost identical. Therefore, we are recommending an RVW of 4.50 for both codes 21030 (median) and 21040 (25<sup>th</sup> percentile).

The IWPUT analysis below shows that and RVW of 4.50 for both codes is reasonable.

Further, the total RVU's for these two codes is less than budget neutral:

<b>CPT</b>	<b>2000 Freq</b>	<b>2002 RVW</b>	<b>Current RVUs</b>	<b>Recom'd. RVW</b>	<b>Estimated RVUs</b>
21030	1,599	6.46	10,330	4.50	7,196
21040	1,110	2.11	2,342	4.50	4,995
<b>Total</b>			<b>12,672</b>		<b>12,191</b>

IWPUT ANALYSIS		Survey CPT code: 21030			Survey CPT code: 21040		
Row	Column	A	B	C	D	E	F
1				MEDIAN Svy RVW: <u>4.50</u>			25 <sup>th</sup> Pctl Svy RVW: <u>4.50</u>
2		Survey Data		RVW	Survey Data		RVW
3	Pre-service	Time	Intensity	(=time x intensity)	Time	Intensity	(=time x intensity)
4	Pre-service	30	0.0224	0.67	30	0.0224	0.67
6	PRE-service total:			<u>0.67</u>			<u>0.67</u>
7	Post-service	Time	Intensity	(=time x intensity)	Time	Intensity	(=time x intensity)
8	Immediate post	15	0.0224	0.34	15	0.0224	0.34
9	Subsequent visits:	Visit n	E/M RVW	(=n x RVW)	Visit n	E/M RVW	(=n x RVW)
19	99215	0	1.73**	0	0	1.73**	0
20	99214	0	1.08**	0	0	1.08**	0
21	99213	1	0.65**	0.65	1	0.65**	0.65
22	99212	2	0.43**	0.86	2	0.43**	0.86
23	99211	0	0.17**	0	0	0.17**	0
24	POST-service total:			<u>1.85</u>			<u>1.85</u>
25		Time	IWPUT	INTRA-RVW	Time	IWPUT	INTRA-RVW
26	INTRA-SERVICE:	33	0.060	<u>1.98</u>	37	0.054	<u>1.98</u>

\*\*Note: Office visit RVW's shown reflect RUC/CMS "discounted" values.

**FREQUENCY INFORMATION**

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

21040 (with and without mod -22) Excision of benign cyst or tumor of mandible; simple

2. How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: maxillofacial surgery, oral surgery      Commonly      Sometimes      Rarely

3. For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: maxillofacial surgery, oral surgery      Frequency: 2,500

4. For your specialty, estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty: maxillofacial surgery, oral surgery      Frequency: 1,100

5. Do many physicians perform this service across the United States or is it limited to a few medical centers?

Many physicians would be able to perform this procedure, if necessary.

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
90 Day Global Period  
Non-facility and Facility Direct Inputs**

CPT	DESCRIPTION	GLOBAL
21030	Excision of benign tumor or cyst of maxilla or zygoma, by enucleation and curettage	90
21040	Excision of benign tumor or cyst of mandible, by enucleation and curettage	90

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

No survey was conducted. The direct practice expense details were jointly developed by physicians from AAOMS.

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time:** Approved typical pre-service period times of 35 minutes for office procedures and 60 minutes for facility procedures have been applied.

**Service period clinical staff time (admission to discharge):** In office day of procedure pre-service and post-service times are based on tasks as shown on the spreadsheet, using EM standards for most tasks. In addition to these EM tasks normally associated with an office visit: two minutes of additional time has been added to office columns for review of patient education/consent prior to performing the procedure; two minutes has been included for specimen/pathology prep and requisition; and three minutes has been included for home care instructions. Intra-service time is equal to physician time. The assignment of 6 minutes for 0.5 x 99238 for discharge management has been applied to both codes for facility columns.

**Post-service period clinical staff time:** Standard EM postop visit times for clinical staff have been applied as appropriate for each code. Additionally, three minutes is shown for followup phone call after patient leaves office/facility for same day.

**SUPPLIES AND EQUIPMENT:**

Supplies and equipment necessary to perform the procedures and for the postop office visits are indicated.

---

	A	B	C	D	E	F	G
1	<b>21030 - 2100 PE Summary</b>	<b>CPT:</b>		<b>21030</b>	<b>21040</b>		
2		<b>DESCRIPTOR:</b>		Excision of benign tumor or cyst of maxilla or zygoma, by enucleation and curettage	Excision of benign tumor or cyst of mandible, by enucleation and curettage		
3		<b>GLOBAL:</b>		<b>90</b>	<b>90</b>		
4		<b>Site and % at site:</b>		<b>Office</b>	<b>Facility</b>	<b>Office</b>	<b>Facility</b>
5	<b>TIME CATEGORIES</b>	<b>Code</b>	<b>Desc</b>	<b>77%</b>	<b>23%</b>	<b>81%</b>	<b>19%</b>
6	<b>PRE-service time</b>	130	RN/LPN/MA	<b>35</b>	<b>60</b>	<b>35</b>	<b>60</b>
7	<b>SERVICE time</b>	130	RN/LPN/MA	<b>64</b>	<b>3</b>	<b>68</b>	<b>3</b>
8	<b>POST-service time</b>	130	RN/LPN/MA	<b>90</b>	<b>90</b>	<b>90</b>	<b>90</b>
9	<b>PRE-SERVICE - BEFORE ADMISSION</b>	<b>Code</b>	<b>Desc</b>				
10	Complete pre-service diagnostic & referral forms (5/5)	130	RN/LPN/MA	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>
11	Coord pre-surgery services, review test/exam results (10/20)	130	RN/LPN/MA	<b>10</b>	<b>20</b>	<b>10</b>	<b>20</b>
12	Schedule space and equipment in facility (0/8)	130	RN/LPN/MA	<b>0</b>	<b>8</b>	<b>0</b>	<b>8</b>
13	Provide pre-service education/obtain consent (10/20)	130	RN/LPN/MA	<b>10</b>	<b>20</b>	<b>10</b>	<b>20</b>
14	Follow-up phone calls & prescriptions (10/7)	130	RN/LPN/MA	<b>10</b>	<b>7</b>	<b>10</b>	<b>7</b>
15	<b>SERVICE PERIOD - ADMISSION TO DISCHARGE</b>	<b>Code</b>	<b>Desc</b>				
16	<b>Before service</b>						
17	Assemble/review X-ray, lab, pathology reports (99213=2)	130	RN/LPN/MA	<b>2</b>	<b>0</b>	<b>2</b>	<b>0</b>
18	Greet patient and provide gowning (peac std=3)	130	RN/LPN/MA	<b>3</b>	<b>0</b>	<b>3</b>	<b>0</b>
19	Obtain vital signs (Vitals 0=0, 1-3=3, 4-6=5)	130	RN/LPN/MA	<b>5</b>	<b>0</b>	<b>5</b>	<b>0</b>
20	Review history, systems, and medications (99213=6)	130	RN/LPN/MA	<b>6</b>	<b>0</b>	<b>6</b>	<b>0</b>
21	Review pre-service education/obtain consent	130	RN/LPN/MA	<b>2</b>	<b>0</b>	<b>2</b>	<b>0</b>
22	Prepare room, equipment, supplies (99213=2)	130	RN/LPN/MA	<b>2</b>	<b>0</b>	<b>2</b>	<b>0</b>
23	<b>Intra-service</b>						
24	Assist Physican during Procedure	130	RN/LPN/MA	<b>33</b>	<b>0</b>	<b>37</b>	<b>0</b>
25	<b>After service</b>						
26	Clean room/equipment (99213=3)	130	RN/LPN/MA	<b>3</b>	<b>0</b>	<b>3</b>	<b>0</b>
27	Complete diagnostic forms, lab & X-ray requisitions	130	RN/LPN/MA	<b>2</b>	<b>0</b>	<b>2</b>	<b>0</b>
28	Home care instructions /coord office vis /Rxs	130	RN/LPN/MA	<b>3</b>	<b>0</b>	<b>3</b>	<b>0</b>
29	<b>Other Clinical Activity (please specify)</b>						
30	99238 discharge visit			<b>0</b>	<b>0.5</b>	<b>0</b>	<b>0.5</b>
31	99238 discharge time	130	RN/LPN/MA	<b>0</b>	<b>6</b>	<b>0</b>	<b>6</b>
32	Communicate with family from office	130	RN/LPN/MA	<b>3</b>	<b>3</b>	<b>3</b>	<b>3</b>
33	<b>POST-SERVICE - AFTER DISCHARGE</b>	<b>Code</b>	<b>Desc</b>				
34	99211 16 minutes						
35	99212 27 minutes			<b>2</b>	<b>2</b>	<b>2</b>	<b>2</b>
36	99213 36 minutes			<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>
37	99214 53 minutes						
38	99215 63 minutes						
39	<b>Total Office Visit Time:</b>	130	RN/LPN/MA	<b>90</b>	<b>90</b>	<b>90</b>	<b>90</b>
40	<b>Other Activity (please specify)</b>						

	A	B	C	D	E	F	G
1	<b>21030 - 2100 PE Summary</b>	<b>CPT:</b>		<b>21030-</b>		<b>21040</b>	
2		<b>DESCRIPTOR:</b>		Excision of benign tumor or cyst of maxilla or zygoma, by enucleation and curettage		Excision of benign tumor or cyst of mandible, by enucleation and curettage	
3		<b>GLOBAL:</b>		<b>90</b>		<b>90</b>	
4		<b>Site and % at site:</b>		<b>Office</b>	<b>Facility</b>	<b>Office</b>	<b>Facility</b>
41	<b>SUPPLIES</b>	<b>Code</b>	<b>Desc</b>				
42	Minimum supply package for visits	PEAC	pack	4	3	4	3
43	<b>DAY OF PROCEDURE</b>						
44	<b>scrub, dress, prep</b>						
45	emesis basin	11506	item	1	0	1	0
46	scrub brush (impregnated)	11119	item	2	0	2	0
47	surgical mask, with face shield	11301	item	2	0	2	0
48	gown, staff, impervious, disposable	11304	item	2	0	2	0
49	surgical cap	11305	item	2	0	2	0
50	gloves, non-sterile	11302	par	3	0	3	0
51	<b>procedure</b>						
52	Suction Canister, Disposable	93604	item	1	0	1	0
53	suction tubing, non-latex, 1' x 1/4" (Busse Co \$1 65 / ft)	new	feet	12	0	12	0
54	suction tip, yankauer (Busse Co @ \$1 35)	new	item	1	0	1	0
55	disposable scalpel # 11,15,20 blade	11504	item	1	0	1	0
56	cotton balls	31102	item	2	0	2	0
57	pad, acetone	31106	item	2	0	2	0
58	band aid, 3/4" x 3"	31502	item	1	0	1	0
59	Gauze, Sterile 4 x 4	31505	item	6	0	6	0
60	Vicryl suture 4-0 and 5-0	31708	item	2	0	2	0
61	Xylocaine w/ epinephrine 1%	51504	ml	10	0	10	0
62	syringe, 3cc, 20 to 25 gauge needle	91406	item	3	0	3	0
63	syringe, 10 cc or 12 cc	91407	item	2	0	2	0
64	syringe, 5 cc	91411	item	1	0	1	0
65	hydrogen peroxide	52303	ml	60	60	0	0
66	sterile specimen cup	14010	item	1	0	1	0
67	Burrs, disposable	new	item	1	0	1	0
68	needle, dental	91404	item	1	0	1	0
69	<b>Other supplies, postop office visits:</b>	<b>Code</b>	<b>Desc</b>				
70	gloves, non-sterile	11302	pair	3	3	3	3
71	emesis basin	11506	item	3	3	3	3
72	gloves, sterile	14005	pair	1	1	1	1
73	suture removal kit	31703	item	1	1	1	1
74	cotton balls	31102	item	2	2	2	2
75	Gauze, Sterile 4 x 4	31505	item	8	8	4	4
76	gauze, 2x2	31506	item	6	6	0	0
77	smelling salts	53083	item	1	1	1	1
78	<b>EQUIPMENT</b>	<b>Code</b>					
79	fiberoptic exam light	E11006		1	1	1	1
80	reclining exam chair with headrest	E11011		1	1	1	1
81	light source	E13122		1	1	1	1
82	suction machine, Gomco	E3001		1	1	1	1
83	surgical dnl system	E72009		1	0	1	0

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2003

**Laparoscopic Hysterectomy/Myomectomy Procedures**

*Interim Recommendation from April 2002 Meeting:*

New codes 58545, 58546, 58550, and 58552-58554 were created to specifically describe vaginal hysterectomy/myomectomy procedures performed on enlarged uteri.

At the April 2002 meeting, the specialty society stated that they would need to re-survey these codes, as the correct global period for these services should be 90 days not 10 days as stated on their survey instrument. The specialty society presented survey data at the February 2003 RUC meeting. In the interim, the RUC recommended that these laparoscopic codes be valued equivalent to the recommended relative work values of the open approach hysterectomy codes as follows:

New Code	Tracking Number	Crosswalk to Code	Work RVU (Interim 2003)
58545	BA1	58140	14.60
58546	BA2	58146	19.00
58550	BA3	58550 (old code number 56308)	14.19 (no change)
58552	BA4	58550 (old code number 56308)	14.19
58553	BA5	58290	19.00
58554	BA6	58290	19.00

58550 and 58552 both compared to 58550 *Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)* (RVU = 14.19) because there is no difference in the work of removing the tube or ovaries in the laparoscopic approach. The same applies to 58553 and 58554 where both are crosswalked to

58290 *Vaginal hysterectomy, for uteri greater than 250 grams* (recommended RVU 19.00). Therefore, the RUC recommended interim 2003 work relative values of 14.60 for 58545, 19.00 for 58546, 14.19 for 58550 and 58552, 19.00 for 58553 and 58554.

*RUC Recommendations from the February 2003 Meeting:*

At the February 2003 meeting, the specialty society presented survey data for all 6 codes. For all codes, the specialty society determined that a 090-day global period should be used for the survey. The RUC expressed concern that the pre-service time of 90 minutes for all six of these procedures is too high and suggested that it be reduced to 60 minutes to be consistent with other major surgical procedures. The specialty society agreed to modify its recommendation of pre-service time to 60 minutes for all six codes. The RUC also discussed the issue of work neutrality for these codes, as the new codes are derived from existing services. The RUC agreed with the specialty that the new codes described new techniques that were not previously performed under the existing codes. In addition, these services would not likely be provided to Medicare patients.

New CPT Codes 58545 *Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; excision of 1-4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas* and 58546, *Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams* replace deleted CPT code 58551 *Laparoscopy, surgical; with removal of leiomyomata (single or multiple)* (work value = 14.21). Old CPT code 58551 was previously assigned a global of 010, while the new CPT codes are assigned a 090 day global. The specialty society had presented a median survey result of 14.86 and an IWPUT comparison to reference code 58140 *Myomectomy, excision of leiomyomata of uterus, single or multiple (separate procedure); abdominal approach* (14.60 RVU). However, the RUC did not agree that the work described in 58545 differed than the work described in the existing code, 58551 (14.21). The RUC recommends the 25<sup>th</sup> percentile of the survey median of 14.21. **The RUC recommends work relative values of 14.21 for code 58545.**

The RUC had previously recommended an interim value of 19.00 for new CPT code 58546, utilizing 58146 *Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams, abdominal approach* (work value = 19.00) as a crosswalk. The specialty society then conducted a survey, which also resulted in a survey median of 19.00. The specialty society's survey indicated more intra-service time for the laparoscopic approach (180 vs. 150 minutes), but a lower amount of hospital visit time (30 vs. 79 minutes). The RUC agreed that the open approach remained an appropriate crosswalk and recommends 19.00 for 58546. The specialty clarified that the post-surgical office visits should be revised from one 99214 visit and one 99212 visit to two 99213 visits. The RUC's comments on the work neutrality above apply to this service. It was

also noted that the services now described by 58546 had previously been performed as open procedures, under code 58146. **The RUC recommends a work relative value of 19.00 for code 58546.**

Existing CPT code 58550 was modified and three new codes ( 58552, 58553, and 58554) were created to specifically differentiate between laparoscopic hysterectomies performed with or without removal of tube(s) and/or ovary(s) and to differentiate based on size of the uteri. CPT code 58550 will now specifically states that it is reported for laparoscopic vaginal hysterectomies only, for uteri less than 250 grams. The RUC understands that this is how this code was originally evaluated when it was added to CPT in 2003. At that time, the work value for this code was determined by comparing the code to CPT 58260 *Vaginal hysterectomy* which did not include the removal of tube(s), and/or ovary(s). The specialty surveyed thirty-six physicians and a consensus panel of physicians to determine the final recommendations for code 58550. For code 58550, a work relative value of 14.19 reflected the 25<sup>th</sup> percentile of survey responses. The validity of the 25<sup>th</sup> percentile value was tested using IWPUT analysis. The specialty society determined that the resulting IWPUT of .08 was an appropriate value for this procedure since the laparoscopic route for hysterectomies is chosen over the vaginal route due to some factor impeding the vaginal route. The RUC agreed that the work relative value for this service should not change for its current value of 14.19. **The RUC recommends a work relative value of 14.19 for CPT code 58550.**

CPT code 58552 *Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)* now describes the services in which the tube(s) and/or ovary(s) are also removed. The work relative value survey median for this service was 16.00. The validity of the median value was checked using IWPUT analysis that resulted in an IWPUT of .07, which the specialty society concluded was appropriate. In addition, the society used a building block approach to validate the recommendation and to identify the appropriate value for removal of tubes and ovary(s). The increment between the laparoscopic hysterectomy only procedure described by 58550 and the hysterectomy with removal of the tube(s) and/or ovaries, described by 58552, was 1.81 RVUs. In comparison to the traditional procedure codes CPT code 58260, *Vaginal hysterectomy* (RVU = 12.98), and CPT code 58262, *Vaginal hysterectomy; with removal of tube(s), and/or ovary(s)* (RVU =14.77) the increment of 1.79 RVUs, is a very similar increment. In addition, when comparing the surveyed code (58550) with similar codes 58150, *Total abdominal hysterectomy*, and CPT code 58260, *Vaginal hysterectomy*, the specialty felt that the relative value recommendation was consistent with other hysterectomy codes. The RUC agreed that the increment and the overall relativity was correct and recommends the survey median of 16.00. **The RUC recommends a work relative value of 16.00 for CPT code 58552.**

New CPT code 58553, *Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; without removal of tube(s) and/or ovary(s)*, and code 58554, *Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)*, were created to reflect new techniques allowing surgeons to remove larger uteri laparoscopically. The specialty society stated that there is additional work with the more complex procedures thereby necessitating the new codes. For code 58553, the specialty society analyzed data received from thirty-one surveys and tested the validity of the median surveyed RVW using IWPUT analysis. The specialty society determined that an IWPUT of 0.08 was an appropriate value for the level of service for these codes. The specialty society also compared the surveyed code 58553 with similar codes 58150, *Total abdominal hysterectomy* and 58290, *Vaginal hysterectomy, for uterus greater than 250 grams*. CPT code 58150 is valued at 15.24 RVW and the RUC approved 19.00 RVW for 58290 at the April 2002 meeting. The RUC agreed with the survey median, which indicated that the median value for code 58553 was 20.00, a value slightly larger than 58290 due to the increased work for removing larger uteri laparoscopically. The specialty modified the post-service visits from one 99214 and one 99212 to two 99213 visits. **The RUC recommends work relative values of 20.00 for CPT code 58553.**

Analysis of the survey results for new CPT code 58554 indicated median of 22.00 RVUs. The specialty society tested the validity of the survey results using IWPUT analysis and found an IWPUT of 0.09. The 0.09 intensity was slightly higher than for 58553. The specialty agreed that complexity and physician skill required of this procedure should result in a greater intensity, and therefore determined it to be appropriate. The specialty compared the difference in similar vaginal procedures CPT code 58260 *Vaginal hysterectomy* (12.98 RVUs) and CPT code 58262, *Vaginal hysterectomy with removal of tubes and ovary(s)* (14.77 RVU). The difference in the work increment between these two codes is 1.79 RVUs. In comparison, the difference in the recommended values for the laparoscopic codes 58553 and 58554 is 2.00 RVUs. The RUC agreed that this increment and the overall relativity for this code was appropriate and recommends the survey median of 22.00. **The RUC recommends work relative values of 22.00 for CPT code 58554.**

#### **Practice Expense**

The RUC approved the practice expense inputs for 58545, 58546, 58550, and 58552-58554. The RUC understood that the 090-day global period standard should apply for all of these codes. The revised practice expense sheets are attached to this recommendation. **The RUC recommends all the practice expense inputs presented by the specialty society.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
λ58545	BA1	Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 1 to 4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas	090	14.21
λ58546	BA2	5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams	090	19.00
▲58550 56308 (old code #)	BA3	Laparoscopy surgical; with vaginal hysterectomy, for uterus 250 grams or less; <del>with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)</del>	090	14.19 (no change)
<del>58551(D)</del> 56309 (old code #)		<del>with removal of leiomyomata (single or multiple)</del> <u>(58551 has been deleted. To report see 58545, 58546)</u>	090	N/A
λ58552	BA4	with removal of tube(s) and/or ovary(s)	090	16.00
λ58553	BA5	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;	090	20.00
λ58554	BA6	with removal of tube(s) and/or ovary(s)	090	22.00

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

CPT Code: 58545

Tracking Number: BA1 Global Period: 090

Recommended RVW:  
RUC Recommendation: 14.21

Deleted: 14.88

**CPT Descriptor:** Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; excision of 1-4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas

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

A 42-year old multigravida woman has been evaluated for an enlarging symptomatic pelvic mass. The uterus has increased from 6-12 weeks' size over 8 months and is causing urinary frequency, nocturia, and dyspareunia. Ultrasound documented a leiomyomatous uterus with two separate myomas 4X5 and 3X4 cm. Management options are discussed with her. The patient expresses a desire to keep her fertility options open and keep her uterus. The patient elects a myomectomy. A laparoscopic myomectomy is performed. All fibroids are removed and the uterine incisions are closed in multiple layers using laparoscopic suturing technique.

**Description of Pre-Service Work:**

The preservice work includes performing a comprehensive preoperative medical history, physical exam including a detailed pelvic exam. A physician must then dictate a history and physical, including writing of all admission orders. The patient is identified in the preoperative holding area with the appropriate consents. Patient identification is verified. The patient's family is also spoken to. All preoperative documentation is also reviewed at this time. This includes imaging studies, including ultrasounds and associated laboratory data. The physician reviews with the OR personnel the operative instrumentation necessary for the advanced laparoscopy. This includes ensuring that the video monitors are in proper working order. The patient is taken to the OR and correctly positioned on the operating table. This includes positioning of the lower extremities to avoid any potential injury.

**Description of Intra-Service Work:**

The patient is prepped and draped in a sterile fashion. A pelvic exam is performed under anesthesia. A Foley catheter is inserted into the bladder. The uterus is sounded. The size and flexion of the uterus is noted and the uterine manipulator is placed. The cervix must be dilated and the uterine manipulator applied. The manipulator allows "hand assistance" of exposing and manipulating the uterus to facilitate surgical removal of myomas. A vertical umbilical incision is then made. A Verres needle is carefully inserted into the abdominal cavity. The insufflator is attached and correct pressure readings reflect proper intraabdominal placement. The abdominal cavity is then insufflated. The Verres needle is removed and a trochar is carefully inserted into the abdominal cavity. The trochar is then removed from the obturator and a 10 mm laparoscope is inserted. The pelvis and lower abdomen are then grossly inspected. A decision is reached on the placement of the lower quadrant trochars. Using the anatomy of the anterior abdominal wall, the sites are chosen for entry of the right and left lower quadrant trochars, which are placed under direct visualization. The patient is then placed in Trendelenberg position. The small and large bowel are carefully grasped and placed in the upper abdomen. The myomas are inspected and a surgical plan is developed as to which myoma to approach first and how surgery shall proceed. A vasopressant agent such as Pitressin may be injected along the myometrium to minimize blood loss. A harmonic scalpel or similar cutting coagulating instrument is utilized to incise the myometrium overlying the fibroids. The incision is made on the uterus parallel to the course of the vascular supply.

Once the myoma has been exposed, it is grasped with a specially designed myoma forceps. Careful dissection is carried to free the myoma from surrounding myometrium. This would be a combination of sharp as well as blunt dissection. If pedicle is identified, it is isolated and independently coagulated and then transected. Once the myoma has been completely removed, hemostasis from the bed of the myoma is achieved. This most often involves a series of laparoscopic sutures. Once hemostasis is achieved within the bed of the myometrium, the uterus itself must be reconstructed. Care is taken to place several sutures through the myometrium. They are then

tted in sequence using extracorporeal knot tying techniques. Depending on size of the myoma itself it is either suture tagged or placed in the cul-de-sac for later retrieval. The second, third and fourth myomas are removed in a similar fashion. Again, care is taken to suture tag the myomas upon their removal. With each myoma there is suture placement for hemostasis within the bed of the myometrium followed by uterine reconstruction. Upon achieving hemostasis and uterine reconstruction, the myomas are then individually retrieved and morcellated. Then the myomas must individually be fed to the morcellator, which removes 1 cm strips of tissue at a time. This process can take a long period of time, depending on the size and nature of the myomas. Once the myomas have been completely removed, the trochars are then removed within the abdominal wall. The trochar sites are closed using again laparoscopic suturing techniques. The skin incision is closed with a subcuticular closure.

**Description of Post-Service Work:**

The patient is accompanied to the recovery room where postoperative orders are written and the operative report is dictated. The patient is evaluated and stabilized. The family is then counseled regarding the results of the procedure and the anticipated convalescence. Once the patient is alert, she too is counseled regarding the outcome of surgery and the anticipated hospital stay and subsequent convalescence. She is monitored the day of surgery as well as the following day in the hospital. She is discharged in the evening or afternoon of post day #1. She will be followed as an outpatient with approximately two to three office visits during the 90-day global period.

**SURVEY DATA**

<b>Presenter(s):</b>	George Hill, MD, FACOG and Sandra Reed, MD, FACOG				
<b>Specialty(s):</b>	American College of Obstetricians and Gynecologists (ACOG)				
<b>CPT Code:</b>	58545, Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus, excision of 1-4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas				
<b>Sample Size:</b>	70	<b>Resp n:</b>	29	<b>Resp %:</b>	41%
<b>Sample Type:</b>	Survey was distributed at the American Association of Gynecological Laparoscopists (AAGL) annual meeting				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	13.1	14.21	16.00	18.00	28
<b>Pre-Service Time: (day preceding procedure)</b>	5	30	30	60	180
<b>Pre-Service Time: (day of procedure)</b>	15	30	30	55	60
<b>Intra-Service Time:</b>	50	90	120	150	210
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	30				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	30	99232/1			
<b>Discharge Day Mgmt:</b>	36	99238/1			
<b>Office time/visit(s):</b>	46	99213/2			

Deleted: 45  
Deleted: 40

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19), 99238 (36); 99215 (59), 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
58140	Myomectomy, excision of leiomyomata of uterus, single or multiple (separate procedure); abdominal approach	90	14.60

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

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

**TIME ESTIMATES (Median)**

New/Revis. CPT Code	Key Reference CPT Code:
<b>5854X</b>	<b>58140</b>

<u>TIME ESTIMATES (Median)</u>	New/Revis. CPT Code <b>5854X</b>	Key Reference CPT Code: <b>58140</b>	
Median Pre-Service Time	60	60	Deleted: 90
Median Intra-Service Time	120	120	
Median Immediate Post-service Time	30	30	
Median Critical Care Time	0	0	
Median Other Hospital Visit Time	30	68	
Median Discharge Day Management Time	36	36	
Median Office Visit Time	46	46	
Median Total Time	322	360	Deleted: 352

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.46	3.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.35	3.73
Urgency of medical decision making	3.23	3.38

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.48	3.80
Physical effort required	4.33	3.64
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.19	3.71
Outcome depends on the skill and judgement of physician	4.44	3.84
Estimated risk of malpractice suit with poor outcome	4.33	3.92

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.46	3.31
Intra-Service intensity/complexity	4.35	3.73
Post-Service intensity/complexity	3.23	3.38

**ADDITIONAL RATIONALE**

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

**SURVEY METHOD**

At the September 2002 RUC meeting, the RUC research subcommittee approved the revised multiple code survey instrument proposed by the American College of Obstetricians and Gynecologists (ACOG).

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey at the November 2002 AAGL annual meeting. Twenty-nine surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted the final recommendations.

**PANEL DISCUSSION**

The panel developed the recommendation in the following manner:

1. Comparing the surveyed code to CPT code 58551
2. Evaluating the recommendation using IWPUT analysis
3. Comparing the surveyed code (58545) with the reference code (58140)
4. Comparing the surveyed code value with other codes

**CPT code 58551**—

CPT code 58551, the previous laparoscopic myomectomy code was valued at 14.21. While it could be argued that the more difficult myomectomies will now be coded by 5854X2, the panel agreed that only a handful of physicians across the country would be performing the more complex myomectomy procedure.

A more significant issue is that the laparoscopic myomectomy went from a 10-day to a 90-day global. The committee agreed that 14.21 was a fair value for a 10-day global but adding the value of the 1 additional hospital visit now that it was a 90 day global was appropriate. This results in an addition of 1-99213:

$$14.21 + 0.65(99231) = 14.86$$

The panel felt this justified the recommendation of 14.86.

IWPUT Analysis

The panel tested the validity of 14.86 using the IWPUT analysis. **Applying the formula to the surveyed code resulted in an IWPUT of .07. The panel concluded that .07 was an appropriate value for this level of service.**

CPT code values: 99232= 1.06; 99238=1.28; 99213= .67

$$14.86 - \{.0224(90\text{min}) + .0224(30\text{ min}) + 1.06 + .1.28 + .67 + .67\} / 120\text{ min} = .07\text{ IWPUT}$$

The panel agreed that a .07 IWPUT was an appropriate intensity level for a laparoscopic myomectomy. The panel discussed .08 being a generally accepted level of intensity for most abdominal surgical procedures. They felt that certain factors of laparoscopic surgery in general and this procedure in particular could justify an even higher level of intensity.

- Laparoscopic surgery does not have the reduced intensity times during opening and closing, as do abdominal surgeries.
- Laparoscopic surgery requires the development of specialized skills
- Laparoscopic surgery requires the physician to view their surgical environment using cameras and other technology
- Laparoscopic myomectomy specifically is not just clipping and taking out an organ but it requires suturing and organ repair This can increase hemostasis.

All of these factors result in high levels of intensity during the surgery.

After reviewing the IWPUT analysis the committee agreed that a recommendation of 14.88 was not only fair but also a conservative recommendation.

Reference code 58140 – Next the panel compared the surveyed code (58545) with the reference code (58140) CPT code 58140 is valued at 14.60 RVW. For your reference, a summary of the times is listed below.

CPT CODE	58545	58140
RVW	14.88	14.60
PRE-SERVICE TIME	60 min	60 min
INTRA SERVICE TIME	120 min	120 min
IMMEDIATE POST-SERVICE TIME	30 min	30 min
HOSPITAL VISITS TIME	30 min	68 min
DISCHARGE TIME	36 min	36 min
OFFICE VISIT TIME	46 min	46 min
TOTAL TIME	322 min	360 min

Deleted: 90 min

Deleted: 352 min

After comparing the data, the recommendation of 14.88 seemed to be an appropriate and fair recommendation.

Other related codes: – The panel compared the surveyed code to other laparoscopic procedures

CPT CODE	Short Descriptor	INTRA SERVICE TIME	RVW	GLOBAL
47564	Laparoscopic cholecystectomy		14.23	90
<b>58545</b>	<b>Laparoscopic myomectomy</b>	<b>90 min</b>	<b>14.88</b>	<b>90</b>
44204	Laparoscopic partial colectomy	180 min	25.08	90
50546	Laparoscopic nephrectomy	205 min	20.48	90

Deleted: 120 min

After reviewing the survey data to other laparoscopic codes in the RUC database the committee felt that the recommendation of 14.86 was consistent with other laparoscopic codes.

The panel concluded their discussion stating they were very comfortable with the recommendation of 14.86 RVW for 58545. They reviewed the data using a number of factors and all of the factors indicated that 14.88 was a reasonable and fair if not somewhat conservative recommendation.

The panel unanimously supported the recommendation of 14.86 RVW for CPT code 58545.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

**FREQUENCY INFORMATION**

How was this service previously reported?

CPT code 58551, Laparoscopy, surgical; with removal of leiomyomata (single or multiple)

(if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty American Association of Gynecological Laparoscopists (AAGL)

- Commonly
- Sometimes
- Rarely

Specialty American College of Obstetricians and Gynecologists (ACOG)

- Commonly
- Sometimes
- Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

It is estimated that 10-15% of abdominal myomectomies are now done laparoscopically

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

It is unlikely that this procedure will be performed on Medicare patients.

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

---

---

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

---

**CPT Code:** 58546    **Tracking Number:** BA2    **Global Period:** 090    **Recommended RVW:** 19 00

**CPT Descriptor:** Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:**

A 35-year old nulligravid patient is evaluated for menorrhagia with anemia. She is recently married and anxious to have children. On examination she is found to have a 16-week size fibroid uterus. Ultrasound confirms a 15cm uterus with six distinct intramural myomas distorting the endometrium. Management options are discussed with her. The patient expresses a desire to keep her fertility options open and keep her uterus. The patient elects a myomectomy. A laparoscopic myomectomy is performed. All fibroids are removed and the uterine incisions are closed in multiple layers using a laparoscopic suturing technique.

**Description of Pre-Service Work:**

The preservice work includes performing a comprehensive preoperative medical history, physical exam including a detailed pelvic exam. A physician must then dictate a history and physical, including writing of all admission orders. The patient is identified in the preoperative holding area with the appropriate consents. Patient identification is verified. The patient's family is also spoken to. All preoperative documentation is also reviewed at this time. This includes imaging studies, including ultrasounds and associated laboratory data. The physician reviews with the OR personnel the operative instrumentation necessary for the advanced laparoscopy. This includes ensuring that the video monitors are in proper working order. The patient is taken to the OR and correctly positioned on the operating table. This includes positioning of the lower extremities to avoid any potential injury.

**Description of Intra-Service Work:**

The patient is prepped and draped in a sterile fashion. A pelvic exam is performed under anesthesia. A Foley catheter is inserted into the bladder. The uterus is sounded. The size and flexion of the uterus is noted and the uterine manipulator is placed. The cervix must be dilated and the uterine manipulator applied. The manipulator allows "hand assistance" of exposing and manipulating the uterus to facilitate surgical removal of myomas. A vertical umbilical incision is then made. A Verres needle is carefully inserted into the abdominal cavity. The insufflator is attached and correct pressure readings reflect proper intraabdominal placement. The abdominal cavity is then insufflated. The Verres needle is removed and a trochar is carefully inserted into the abdominal cavity. The trochar is then removed from the obturator and a 10 mm laparoscope is inserted. The pelvis and lower abdomen are then grossly inspected. A decision is reached on the placement of the lower quadrant trochars. Using the anatomy of the anterior abdominal wall, the sites are chosen for entry of the right and left lower quadrant trochars, which are placed under direct visualization. The patient is then placed in Trendelenberg position. The small and large bowel are carefully grasped and placed in the upper abdomen. The myomas are inspected and a surgical plan is developed as to which myoma to approach first and how surgery shall proceed. A vasopressant agent such as Pitressin may be injected along the myometrium to minimize blood loss. A harmonic scalpel or similar cutting/coagulating instrument is utilized to incise the myometrium overlying the fibroids. The incision is made on the uterus parallel to the course of the vascular supply.

Once the myoma has been exposed, it is grasped with a specially designed myoma forceps. Careful dissection is carried to free the myoma from surrounding myometrium. This would be a combination of sharp as well as blunt dissection. If pedicle is identified, it is isolated and independently coagulated and then transected. Once the myoma has been completely removed, hemostasis from the bed of the myoma is achieved. This most often involves a series of laparoscopic sutures. Once hemostasis is achieved within the bed of the myometrium, the uterus itself must be reconstructed. Care is taken to place several sutures through the myometrium. They are then tied in sequence using extracorporeal knot tying techniques. Depending on size of the myoma itself it is either

suture tagged or placed in the cul-de-sac for later retrieval. Four additional myomas are removed in a similar fashion. Again, care is taken to suture tag the myomas upon their removal. With each myoma there is suture placement for hemostasis within the bed of the myometrium followed by uterine reconstruction. Upon achieving hemostasis and uterine reconstruction, the myomas are then individually retrieved and morcellated. Then the myomas must individually be fed to the morcellator, which removes 1 cm strips of tissue at a time. This process can take a long period of time, depending on the size and nature of the myomas. Once the myomas have been completely removed, the trochars are then removed within the abdominal wall. The trochar sites are closed using again laparoscopic suturing techniques. The skin incision is closed with a subcuticular closure.

**Description of Post-Service Work:**

The patient is accompanied to the recovery room where postoperative orders are written and the operative report is dictated. The patient is evaluated and stabilized. The family is then counseled regarding the results of the procedure and the anticipated convalescence. Once the patient is alert, she too is counseled regarding the outcome of surgery and the anticipated hospital stay and subsequent convalescence. She is monitored the day of surgery as well as the following day in the hospital. She is discharged in the evening or afternoon of post day #1. She will be followed as an outpatient with approximately two to three office visits during the next 90day global period.

**SURVEY DATA**

<b>Presenter(s):</b>	George Hill, MD, FACOG and Sandra Reed, MD, FACOG				
<b>Specialty(s):</b>	American College of Obstetricians and Gynecologists (ACOG)				
<b>CPT Code:</b>	58546, Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams				
<b>Sample Size:</b>	70	<b>Resp n:</b>	21	<b>Resp %:</b>	30%
<b>Sample Type:</b>	Survey was distributed at the American Association of Gynecological Laparoscopists (AAGL) annual meeting.				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	14.21	17.85	19.00	23.50	28.85
<b>Pre-Service Time: (day preceding procedure)</b>	15	30	30	60	90
<b>Pre-Service Time: (day of procedure)</b>	45	30	30	60	60
<b>Intra-Service Time:</b>	75	150	180	210	290
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	30				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	30	99232/1			
<b>Discharge Day Mgmt:</b>	36	99238/1			
<b>Office time/visit(s):</b>	46	2 - 99213			

Deleted: 60

Deleted: 45

Deleted: 53

Deleted: 99214/1 and 99212/1

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30), 99233 (41), 99232 (30); 99231 (19); 99238 (36); 99215 (59), 99214 (38); 99213 (23); 99212 (15); 99211 (7)

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
58140	Myomectomy, excision of leiomyomata of uterus, single or multiple (separate procedure); abdominal approach	90	14.60

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

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

**TIME ESTIMATES (Median)**

New/Revis. CPT Code	Key Reference CPT Code:
<u>58546</u>	<u>58140</u>

TIME ESTIMATES (Median)	New/Revis. CPT Code	Key Reference CPT Code:	
Median Pre-Service Time	60	60	Deleted: 90
Median Intra-Service Time	180	120	
Median Immediate Post-service Time	30	30	
Median Critical Care Time	0	0	
Median Other Hospital Visit Time	30	68	
Median Discharge Day Management Time	36	36	
Median Office Visit Time	46	46	Deleted: 53
Median Total Time	382	360	Deleted: 419

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.94	3.47
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.0	3.73
Urgency of medical decision making	3.72	3.60

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.67	3.87
Physical effort required	4.61	3.80
<b>Psychological Stress (Mean)</b>		
The risk of significant complications, morbidity and/or mortality	4.56	4.00
Outcome depends on the skill and judgement of physician	4.78	3.87
Estimated risk of malpractice suit with poor outcome	4.39	4.07

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.72	3.59
Intra-Service intensity/complexity	4.72	4.00
Post-Service intensity/complexity	3.67	3.59

**ADDITIONAL RATIONALE**

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

**SURVEY METHOD**

At the September 2002 RUC meeting, the RUC research subcommittee approved the revised multiple code survey instrument proposed by the American College of Obstetricians and Gynecologists (ACOG)

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey at the November 2002 AAGL annual meeting. Twenty-one surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted the final recommendations.

**PANEL DISCUSSION**

The panel developed the recommendation in the following manner.

1. Reviewing the survey data
2. Comparing the surveyed code (58546) with the reference code (58140)
3. Compared the surveyed code with other laparoscopic codes
4. Comparing the surveyed value of the code with the interim value

Survey Data – ACOG received nineteen completed surveys. The median RVW from the data was 19.00.

The panel tested the validity of the median surveyed RVW using IWPUT analysis. **Applying the formula to the surveyed code resulted in an IWPUT of .07. The panel concluded that .07 was an appropriate value for this level of service.**

CPT code values: 99232= 1.06, 99238=1.28; 99214= 1.10; 99212= .45

$19.00 - \{.0224(90\text{min}) + .0224(30\text{ min}) + 1.06 + .1.28 + .1.10 + .45\} / 180\text{ min} = .07\text{ IWPUT}$

Many of the same issues regarding laparoscopic procedures as described in the recommendation form for 5854X1 were again discussed. In addition, the panel discussed the difference between this code and the simple laparoscopic myomectomy. The entire panel agreed that very few physicians perform the more complex myomectomy procedure. CPT code 58546 is much more surgically challenging and requires a much higher surgical skill level. While only a few physicians currently will use this code, the panel emphasized the importance in encouraging physicians to expand their surgical skills. As discussed in the CPT proposal, doing this procedure laparoscopically versus abdominally has a variety of benefits for the patient.

Reference code 58140 – Next the panel compared the surveyed code (58546) with the reference code (58140). CPT code 58140 is values at 14.60 RVW. For your reference, a summary of the times is listed below.

CPT CODE	5854X1	58140
RVW	19.00	14.60
PRE-SERVICE TIME	60 min	60 min
INTRA SERVICE TIME	180 min	120 min
IMMEDIATE POST-SERVICE TIME	30 min	30 min
HOSPITAL VISITS TIME	30 min	36 min
DISCHARGE TIME	36 min	68 min
OFFICE VISIT TIME	46 min	46 min
TOTAL TIME	389 min	360 min

Deleted: 90 min

Deleted: 53 min

Deleted: 419 min

The panel concluded that the greater physician time reflected in the data for 58546 justified the higher RVW.

Other laparoscopic procedures

The panel also compared the surveyed code to other laparoscopic codes.

CPT CODE	Short Descriptor	INTRA SERVICE TIME	RVW	GLOBAL
47564	Laparoscopic cholecystectomy		14.23	90
5854X	Laparoscopic myomectomy	120 min	19.00	90
44204	Laparoscopic partial colectomy	180 min	25.08	90
50546	Laparoscopic nephrectomy	205 min	20.48	90

Deleted: 180

After reviewing the survey data to other laparoscopic codes in the RUC database the committee felt that the recommendation of 19.00 was consistent with other laparoscopic codes.

Interim value – When comparing the surveyed code to the interim value the recommended RVW seemed to be appropriate and fair 19.00 RVW was also recommended in April 2002 for the interim value.

The panel supports the recommendation of 19.00 RVW for 58546.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

---

---

**FREQUENCY INFORMATION**

How was this service previously reported?

CPT code 58551, Laparoscopy, surgical; with removal of leiomyomata (single or multiple)

(if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty American Association of Gynecological Laparoscopists (AAGL)

\_\_\_\_ Commonly

**X** Sometimes

\_\_\_\_ Rarely

Specialty American College of Obstetricians and Gynecologists (ACOG)

\_\_\_\_ Commonly

\_\_\_\_ Sometimes

**X** Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

**It is estimated that 10-15% of abdominal myomectomies are now done laparoscopically**

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

**It is unlikely that this procedure will be performed on Medicare patients.**

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Do many physicians perform this service across the United States? **X** Yes \_\_\_\_ No

---

---

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATIONCPT Code: 58550 Tracking Number: BA3 Global Period: 090 Recommended RVW: 14.19

CPT Descriptor: Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less

## CLINICAL DESCRIPTION OF SERVICE:

**Vignette Used in Survey:**

A 45 year-old G1P1 is evaluated for profound menorrhagia with anemia. Her hematocrit is 25% despite daily iron therapy and treatment with oral contraceptives. On physical examination she has an irregular, mobile 4-6 week size fibroid uterus. Ultrasound confirms multiple uterine fibroids, several of which impinge on the endometrium. After management options are discussed with her, the patient elects a hysterectomy. A laparoscopic assisted vaginal hysterectomy (LAVH) is performed.

**Description of Pre-Service Work:**

The preservice work includes performing a comprehensive preoperative medical history, physical exam including a detailed pelvic exam. A physician must then dictate a history and physical, including in writing of all admission orders. The patient is identified in the preoperative holding area with the appropriate consents. Patient identification is verified. The patient's family is also spoken to. All preoperative documentation is also reviewed at this time. This includes imaging studies, including ultrasounds and associated laboratory data. The physician reviews with the OR personnel the operative instrumentation necessary for the advanced operative laparoscopy. This includes ensuring that video monitors are in proper working order. The patient is taken to the OR and correctly positioned on the operating table. This includes positioning of the lower extremities to avoid any potential injury. The physician also will position the monitors prior to the beginning of the case.

**Description of Intra-Service Work:**

After general anesthesia is obtained, an exam under anesthesia is performed and compared to operative finding. The patient is then prepped and draped in the usual sterile fashion. In the dorsal lithotomy position a Foley catheter is then inserted to provide a means of intermittent bladder drainage. A weighted speculum is placed into the patient's vagina and the anterior lip of the cervix is grasped using a single tooth tenaculum. The uterus is then sounded and the cervix is then dilated in order to facilitate the Valchev uterine manipulator. The weighted speculum is then removed.

The laparoscopic portion of the procedure is begun by first placing the Verres needle umbilically and achieving an adequate pneumoperitoneum. A 10 mm trocar is then placed at this site and a laparoscope is used to confirm appropriate entrance and no injury to any pelvic or abdominal structures. Next, using laparoscopic guidance, two additional 10 mm trocar ports are then placed in the right and left lower quadrant. A careful inspection of the abdomen and pelvis are made and findings documented. The ureters are then carefully identified bilaterally. The procedure is then begun by using either the Seitzinger (tripolar) forceps or using the harmonic scalpel. The round ligaments are identified bilaterally, clamped, cauterized and transected. The uteroovarian vasculature is clamped, cauterized and suture ligated until freed from the fundal region of the uterus bilaterally.

Next, attention is turned to the vaginal portion of the procedure. The Valchev uterine manipulator is removed and the single tooth tenaculum is repositioned to provide a means of traction on the uterus. Using the Bovie, a circumferential incision is made at the cervicovaginal junction. Using careful sharp dissection, the anterior and posterior cul-de-sacs are entered sharply. The posterior peritoneum is identified and a figure-of-eight stay sutures then placed for hemostasis and securement of the posterior peritoneum.

A narrow weighted speculum is then placed in the posterior cul-de-sac and using Haney clamps the uterosacral ligaments, cardinal and broad ligament are bilaterally clamped, cut and suture ligated. Hemostasis is assured. Once completely freed, the uterus is then delivered. Both ovaries are identified and all pedicles are assured for hemostasis. The hysterectomy portion of the procedure is complete. The peritoneum and vaginal cuff are closed.

in the usual fashion. Attention is then turned to the abdominal incisions where the trochars are removed and the abdominal incisions are closed in the usual fashion.

**Description of Post-Service Work:**

The patient is accompanied to the recovery room where postoperative orders are written and the operative report is dictated. The patient is evaluated and stabilized. The family is then counseled regarding the results of the procedure and the anticipated convalescence. Once the patient is alert, she too is counseled regarding the outcome of the surgery and the subsequent convalescence. She is monitored the day of surgery as well as the following hospital day in the hospital. She is discharged in the evening or afternoon of post op day #1. She will be followed as an outpatient with approximately two to three office visits during the 90-day global period.

**SURVEY DATA**

<b>Presenter(s):</b>	George Hill, MD, FACOG and Sandra Reed, MD, FACOG				
<b>Specialty(s):</b>	American College of Obstetricians and Gynecologists (ACOG)				
<b>CPT Code:</b>	58550, Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less				
<b>Sample Size:</b>	70	<b>Resp n:</b>	36	<b>Resp %:</b>	51%
<b>Sample Type:</b>	Survey was distributed at the American Association of Gynecological Laparoscopists (AAGL) annual meeting.				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	13.25	14.19	15.00	18.00	28.14
<b>Pre-Service Time: (day preceding procedure)</b>	0	30	30	60	90
<b>Pre-Service Time: (day of procedure)</b>	15	30	30	50	60
<b>Intra-Service Time:</b>	15	80	100	120	180
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	30				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	38	99231/2			
<b>Discharge Day Mgmt:</b>	36	99238/1			
<b>Office time/visit(s):</b>	61	99213/2 and 99212/1			

Deleted: 40

Deleted: 45

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19), 99238 (36); 99215 (59); 99214 (38), 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
58550	Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)	10	14 19

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

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

**TIME ESTIMATES (Median)**

<u>New/Revis. CPT Code</u>	<u>Key Reference CPT Code:</u>
<u>58550</u>	<u>58550</u>

<u>TIME ESTIMATES (Median)</u>	<u>New/Revis. CPT Code</u>	<u>Key Reference CPT Code:</u>
Median Pre-Service Time	.60	
Median Intra-Service Time	100	
Median Immediate Post-service Time	30	
Median Critical Care Time	0	
Median Other Hospital Visit Time	38	
Median Discharge Day Management Time	36	
Median Office Visit Time	61	
Median Total Time	.325	

Deleted: 90

Deleted: 355

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.68	3.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.48
Urgency of medical decision making	3.28	3.23

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.24	3.76
Physical effort required	3.94	3.58

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.03	3.79
Outcome depends on the skill and judgement of physician	4.26	3.94
Estimated risk of malpractice suit with poor outcome	4.21	4.00

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference  
Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	4.06	3.67
Intra-Service intensity/complexity	3.82	3.18
Post-Service intensity/complexity	3.68	3.55

**ADDITIONAL RATIONALE**

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

**SURVEY METHOD**

At the September 2002 RUC meeting, the RUC research subcommittee approved the revised multiple code survey instrument proposed by the American College of Obstetricians and Gynecologists (ACOG).

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey at the November 2002 AAGL annual meeting. Thirty-six surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted the final recommendations.

**PANEL DISCUSSION**

The panel developed the recommendation in the following manner:

1. Reviewing the survey data
2. Comparing the surveyed code (58550) with similar codes
3. Comparing the surveyed value with the interim value

Survey Data – ACOG received thirty-four completed surveys. The 25<sup>th</sup> percentile RVW from the data was 14.19. The panel tested the validity of the 25<sup>th</sup> percentile value using IWPUT analysis. **Applying the formula to the surveyed code resulted in an IWPUT of .08. The panel concluded that .08 was an appropriate value for this procedure.** In their experience the panel agreed that generally laparoscopic hysterectomies are a little more difficult than vaginal hysterectomies because the laparoscopic route is chosen over the vaginal route due to some factor impeding the vaginal route.

CPT code values: 99231= .64, 99238=1.28; 99213= 0.65; 99212= 0.43

$$14.19 - \{.0224(60\text{min}) + .0224(30\text{ min}) + .64 + 1.28 + .67 + .67 + .45\} / 100\text{ min} = .08\text{ IWPUT}$$

Similar code s – Next the panel compared the surveyed code (5854X2) with similar codes 58150, Total abdominal hysterectomy and CPT code 58260, Vaginal hysterectomy. For your reference, a summary of the times for both codes is listed below.

CPT CODE	58550	58260	58150
RVW	14.19	12.98	15.24
PRE-SERVICE TIME	60 min	60 min	60 min
INTRA SERVICE TIME	100 min	60 min	120 min
IMMEDIATE POST-SERVICE TIME	30 min	30 min	40 min
HOSPITAL VISITS TIME	38 min	49 min	87 min
DISCHARGE TIME	36 min	36 min	36 min
OFFICE VISIT TIME	61 min	61 min	46 min
TOTAL TIME	325 min	296 min	389 min

Deleted: 90 min

Deleted: 355 min

After reviewing this data the panel felt that the recommendation was consistent with other hysterectomy codes.

Interim value – The panel also compared the survey value of the code with the interim value. It was the same. The panel agreed that the survey results validated the interim values.

The panel supports the recommendation of 14.19 RVW for 58550.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

**FREQUENCY INFORMATION**

How was this service previously reported?

CPT code **58550, Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)**

(if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty American Association of Gynecological Laparoscopists (AAGL)

     Commonly

**X** Sometimes

     Rarely

Specialty American College of Obstetricians and Gynecologists (ACOG)

     Commonly

     Sometimes

**X** Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

**It is estimated that 10-15% of abdominal hysterectomies are now done laparoscopically**

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

**It is unlikely that this procedure will be performed on Medicare patients.**

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

---

---

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION

---

CPT Code: 58552    Tracking Number: BA4    Global Period: 090    Recommended RVW: 16 00

**CPT Descriptor:** Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)

---

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

A 45 year-old G1P1 is evaluated for profound menorrhagia with anemia. Her hematocrit is 25% despite daily iron therapy and treatment with oral contraceptives. On physical examination she has an irregular, mobile 4-6 week size fibroid uterus. Ultrasound confirms multiple uterine fibroids, several of which impinge on the endometrium. After management options are discussed with her, the patient elects a hysterectomy. A laparoscopic assisted vaginal hysterectomy (LAVH) is performed. The patient has a strong history of ovarian cancer in her family and does not desire any more children therefore her tube(s) and ovary(s) removed.

**Description of Pre-Service Work:**

The preservice work includes performing a comprehensive preoperative medical history, physical exam including a detailed pelvic exam. A physician must then dictate a history and physical, including in writing of all admission orders. The patient is identified in the preoperative holding area with the appropriate consents. Patient identification is verified. The patient's family is also spoken to. All preoperative documentation is also reviewed at this time. This includes imaging studies, including ultrasounds and associated laboratory data. The physician reviews with the OR personnel the operative instrumentation necessary for the advanced operative laparoscopy. This includes ensuring that the video monitors are in proper working order. The patient is taken to the OR and correctly positioned on the operating table. This includes positioning of the lower extremities to avoid any potential injury. The physician also will position the monitors prior to the beginning of the case.

**Description of Intra-Service Work:**

After general anesthesia is obtained and the patient is prepped and draped in the usual sterile fashion, an exam under anesthesia is to be performed and compared to preoperative findings.

The procedure begins with placing a weighted speculum into the patient's vagina. The anterior lip of the cervix is grasped using a single tooth tenaculum and the uterus is then sounded. Next, the cervix is then dilated beginning with a #9 French and progressing to a #18 French dilator. This facilitates the placement of a Valchev uterine manipulator, which is then placed into the cervix and connected with a single tooth tenaculum to provide means of manipulating the uterus. At that time the weighted speculum is removed and a Foley catheter is placed to provide intermittent bladder drainage. The laparoscopic portion of the procedure then ensues by first elevating the abdomen and placing the Verres needle into the abdominal cavity and insufflating the abdomen until an adequate pneumoperitoneum is achieved. Once an adequate pneumoperitoneum is achieved, a 10 mm trochar is placed umbilically. A laparoscope is then used to confirm adequate placement and to also verify no injury to any adjacent structures intrabdominally. Next, two additional 10 mm trochar ports are placed in the right lower quadrant and left lower quadrant using laparoscopic guidance so to avoid any vascular guidance. Next, using either the Seitzinger (tripolar) forceps or the harmonic scalpel, the infundibular pelvic ligaments bilaterally are clamped, cauterized and transected. Next, the round ligaments bilaterally are identified, clamped, cauterized and transected. Both ureters are identified bilaterally. At that time the abdominal portion of the procedure is completed. The laparoscope is removed from the patient's abdomen and all gas is allowed to exsufflate from the patient's abdomen. At that time a weighted speculum is placed in the patient's vagina and the Valchev uterine manipulator is removed. The single tooth tenaculum is then used to grasp the cervix for traction purposes. A circumferential incision is then made around the cervix. Next, using sharp dissection, the cervicovesical space is entered anteriorly. Next, in a similar fashion the posterior cul-de-sac is entered using careful sharp dissection. The peritoneum is identified. A figure-of-eight stay suture is placed for hemostasis and securement of the posterior peritoneum. A long narrow weighted speculum is placed in the posterior cul-de-sac. Haney clamps are placed at

the uterosacral ligaments which are then incised and suture ligated. This is carried bilaterally in an ascending fashion. Haney clamps are intermittently placed on the immediate paracervical tissue, which is then incised and suture ligated individually. This is carried out along the length of the uterus. Uterine artery vasculature is carefully identified, clamped, incised and suture ligated. The anterior peritoneal fold is identified and incised. The anterior cul-de-sac is entered and the bladder is then retracted anteriorly. Continued intermittent clamping, incising and suture ligation of the paramaterial tissue is carried out along the length of the uterus. Uterine artery vasculature is carefully identified, clamped, incised and suture ligated. The anterior peritoneal field is identified and incised. The anterior cul-de-sac is entered and the bladder is then retracted anteriorly. Continued intermittent clamping, incising and suture ligation of the paramaterial tissue is carried out along the broad ligament until finally the cornual region of the uterus is reached. The uterus, tubes and ovaries are then removed and handed off the field. All pedicles are carefully inspected and hemostasis is assured. The peritoneum and vaginal cuff is closed in the usual fashion.

Next, attention is then redirected to the abdominal incisions which are closed in subcuticular fashion after careful inspection using a laparoscope. The pedicles are yet again identified and inspected and hemostasis is assured. The laparoscope and all trochars are removed and the abdominal incisions are closed in the usual fashion.

**Description of Post-Service Work:**

The patient is accompanied to the recovery room where postoperative orders are written and the operative report is dictated. The patient is evaluated and stabilized. The family is counseled regarding the results of the procedure and the anticipated convalescence. Once the patient is alert, she too is counseled regarding the outcome of the surgery and the anticipated hospital stay and subsequent convalescence. She is monitored the day of the surgery as well as the following day in the hospital. She is discharged in the evening or afternoon of post day #1. She will be followed as an outpatient with approximately two to three office visits during the 90-day global period.

**SURVEY DATA**

<b>Presenter(s):</b>	George Hill, MD, FACOG and Sandra Reed, MD, FACOG				
<b>Specialty(s):</b>	American College of Obstetricians and Gynecologists (ACOG)				
<b>CPT Code:</b>	58552, Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less, with removal of tube(s) and/or ovary(s)				
<b>Sample Size:</b> 70	<b>Resp n:</b> 35	<b>Resp %:</b> 50%			
<b>Sample Type:</b>	Survey was distributed at the American Association of Gynecological Laparoscopists (AAGL) annual meeting.				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	13.5	14.64	16	19.5	30.19
<b>Pre-Service Time: (day preceding procedure)</b>	0	30	30	60	90
<b>Pre-Service Time: (day of procedure)</b>	15	30	30	50	60
<b>Intra-Service Time:</b>	15	90	120	140	200
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	30				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	38	99231/2			
<b>Discharge Day Mgmt:</b>	36	99238/1			
<b>Office time/visit(s):</b>	61	99213/2 and 99212/1			

Deleted: 45  
Deleted: 45

\*Physician standard total minutes per E/M visit. 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19), 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
58550	Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)	10	14 19

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

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

**TIME ESTIMATES (Median)**

<u>New/Revis. CPT Code</u>	<u>Key Reference CPT Code:</u>
<u>58552</u>	<u>58550</u>

<u>TIME ESTIMATES (Median)</u>	<u>New/Revis. CPT Code</u>	<u>Key Reference CPT Code:</u>
Median Pre-Service Time	.60	
Median Intra-Service Time	120	
Median Immediate Post-service Time	30	
Median Critical Care Time	0	
Median Other Hospital Visit Time	38	
Median Discharge Day Management Time	36	
Median Office Visit Time	61	
Median Total Time	345	

Deleted: 90

Deleted: 375

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.75	3.52
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	3.42
--	------	------

Urgency of medical decision making	3.82	3.20
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.41	3.82
--------------------------	------	------

Physical effort required	4.24	3.64
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.18	3.82
---	------	------

Outcome depends on the skill and judgement of physician	4.38	4.00
Estimated risk of malpractice suit with poor outcome	4.32	4.03

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.54	3.32
Intra-Service intensity/complexity	4.19	3.76
Post-Service intensity/complexity	3.54	3.32

**ADDITIONAL RATIONALE**

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

**SURVEY METHOD**

At the September 2002 RUC meeting, the RUC research subcommittee approved the revised multiple code survey instrument proposed by the American College of Obstetricians and Gynecologists (ACOG).

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey at the November 2002 AAGL annual meeting. Thirty-five surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted the final recommendations.

**PANEL DISCUSSION**

The panel developed the recommendation in the following manner:

1. Reviewing the survey data using IWPUT analysis
2. Reviewing the survey data using the building block approach

IWPUT analysis – ACOG received thirty-three completed surveys. The median RVW from the data was 16.00. The panel tested the validity of the median surveyed RVW using IWPUT analysis. **Applying the formula to the surveyed code resulted in an IWPUT of .07. The panel concluded that .07 was an appropriate value for this level of service.**

CPT code values: 99231= .64; 99238=1.28, 99213= .67; 99212= .45

$16.00 - \{.0224(60\text{min}) + .0224(30\text{ min}) + .64 + .64 + .1.28 + .67 + .67 + .45\} / 120\text{ min} = .07\text{ IWPUT}$

Building block approach – The panel used the building block approach to validate the recommendation and to identify the appropriate value for removal of tubes and ovary(s).

CPT code 58550, Laparoscopic hysterectomy less than 250 grams = 14.19 RVUs

CPT code 58661, Laparoscopic removal of tubes and ovary(s) = 11.05

14.19 + .50(11.05) = 19.72

Another method is to compare the difference in similar vaginal

CPT code 58260 Vaginal hysterectomy = 12.98

CPT code 58262, Vaginal hysterectomy with removal of tubes and ovary(s) = 14.77

14.77 - 12.98 = 1.79

The difference between these two codes is 1.79 RVUs. Similarly the difference in the recommended laparoscopic codes is 1.81.

CPT code 58550, Laparoscopic hysterectomy = 14.19

CPT code 5854X1, Laparoscopic hysterectomy with removal of tubes and ovary(s) = 16.00

16.00 - 14.19 = 1.81

The panel agreed that both methods validate the survey median of 16.00 RVW for this code

The panel concluded discussion of this code by unanimously supporting the recommendation of 16.00 RVW for 58552.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

**FREQUENCY INFORMATION**

How was this service previously reported?

CPT code 58550, Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)

(if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty

Specialty American Association of Gynecological Laparoscopists (AAGL)  
 Commonly  
 Sometimes  
 Rarely

Specialty American College of Obstetricians and Gynecologists (ACOG)  
 Commonly  
 Sometimes  
 Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty

**It is estimated that 10-15% of abdominal hysterectomies are now done laparoscopically**

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_  
Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

**It is unlikely that this procedure will be performed on Medicare patients.**

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_  
Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

---

---

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATIONCPT Code: 58553    Tracking Number: B5    Global Period: 090    Recommended RVW: 20 00

CPT Descriptor: Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams

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

A 45 year-old G1P1 is evaluated for profound menorrhagia with anemia. Her hematocrit is 25% despite daily iron therapy and treatment with oral contraceptives. On physical examination she has an irregular, mobile 12-14 week size fibroid uterus. Ultrasound confirms multiple uterine fibroids, several of which impinge on the endometrium. After management options are discussed with her, the patient elects a hysterectomy. A laparoscopic assisted vaginal hysterectomy (LAVH) is performed.

**Description of Pre-Service Work:**

The preservice work includes performing a comprehensive preoperative medical history, physical exam including a detailed pelvic exam. A physician must then dictate a history and physical, including in writing of all admission orders. The patient is identified in the preoperative holding area with the appropriate consents. Patient identification is verified. The patient's family is also spoken to. All preoperative documentation is also reviewed at this time. This includes imaging studies, including ultrasounds and associated laboratory data. The physician reviews with the OR personnel the operative instrumentation necessary for the advanced operative laparoscopy. This includes ensuring that the video monitors are in proper working order. The patient is taken to the OR and correctly positioned on the operating table. This includes positioning of the lower extremities to avoid any potential injury. The physician also will position the monitors prior to the beginning of the case.

**Description of Intra-Service Work:**

After being placed on the operating room table, general anesthesia is obtained and an exam under anesthesia is performed and compared to preoperative findings. The patient is prepped and draped in the usual sterile fashion. A Foley catheter is then placed to provide a means for intermittent bladder drainage. Next, attention is then turned to the placement of a weighted speculum. The anterior lip of the cervix is grasped using a single tooth tenaculum and the Valchev uterine manipulator is placed and attached to the single tooth tenaculum. Attention is then directed to the abdominal portion of the procedure where the abdomen is tented and the Verres needle is placed through the umbilicus. An adequate pneumoperitoneum is achieved. The Verres needle is then removed and a 10 mm trochar is placed. Using the laparoscope, confirmation of no abdominal or pelvic injuries. Next, using the laparoscopic assisted guidance, a right and left lower quadrant 10 mm trochar port is placed ensuring that there is no injury to the abdominal wall vasculature. At this time, decompression of the uterus is performed by performing multiple myomectomies. Multiple large myomas are noted and injected with a solution of dilute Pitressin. Using the harmonic scalpel, the surface of the myomas are incised along their length, and using a combination of blunt and sharp dissection, the myomas are grasped and removed by a means of sharp and blunt dissection. These myomas are then sutured, tagged and placed into the posterior cul-de-sac to be removed at the time of the vaginal portion of the procedure. After adequate decompression is performed, the fibroid beds are then cauterized to achieve adequate hemostasis. Next, attention is then turned to the round ligaments which are then clamped, cauterized and transected bilaterally. Next, the uteroovarian vasculature is again clamped, cauterized and transected bilaterally. Hemostasis is assured.

Next, attention is then turned to the vaginal portion of the procedure. All air is allowed to be exsufflated from the patient's abdomen and the laparoscope is removed. The Valchev uterine manipulator is then removed and the single tooth tenaculum is repositioned for means of traction of the uterus. Using the Bovie, the cervix is then incised circumferentially at the cervicovaginal junction. The anterior and posterior cul-de-sacs are entered carefully using sharp dissection. The peritoneum is identified posteriorly and a figure-of-eight stay suture is placed for hemostasis and securement of the posterior peritoneum. Next, a narrow weighted speculum is placed in the posterior cul-de-sac. Using Haney clamps, the uterosacral, cardinal and broad ligaments are bilaterally

clamped, cut and ligated. This is continued until the fundal region is reached. At that time the uterine specimen is delivered and handed off field. General traction and palpation of the ovaries is done at this time and the pedicles are inspected for excellent hemostasis. After all pedicles are carefully inspected to ensure hemostasis, the peritoneum and vaginal cuff are closed in the usual fashion. Attention is then directed toward the abdomen where, after trochar removal, these abdominal incisions are also closed in the usual fashion.

**Description of Post-Service Work:**

The patient is accompanied to the recovery room where postoperative orders are written and the operative report is dictated. The patient is evaluated and stabilized. The family is then counseled regarding the results of the procedure and the anticipated convalescence. Once the patient is alert, she too is counseled regarding the outcome of the surgery and the anticipated hospital stay and subsequent convalescence. She is monitored the day of surgery as well as the following day in the hospital. She is discharged in the evening or afternoon of post day #1. She will be followed as an outpatient with approximately two or three office visits during the next 90-day global period.

**SURVEY DATA**

<b>Presenter(s):</b>	George Hill, MD, FACOG and Sandra Reed, MD, FACOG				
<b>Specialty(s):</b>	American College of Obstetricians and Gynecologists (ACOG)				
<b>CPT Code:</b>	58553, Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams				
<b>Sample Size:</b>	70	<b>Resp n:</b>	33	<b>Resp %:</b>	47%
<b>Sample Type:</b>	Survey was distributed at the American Association of Gynecological Laparoscopists (AAGL) annual meeting.				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	14.19	17.75	20	23.13	32.14
<b>Pre-Service Time: (day preceding procedure)</b>	5	27.5	30	60	120
<b>Pre-Service Time: (day of procedure)</b>	0	30	30	50	60
<b>Intra-Service Time:</b>	30	120	150	180	240
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	37.5				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	49	99232/1 and 99231/1			
<b>Discharge Day Mgmt:</b>	36	99238/1			
<b>Office time/visit(s):</b>	46	2x 99213			

Deleted: 42 5

Deleted: 45

Deleted: 53

Deleted: 99214/1 and 99212/1

\*Physician standard total minutes per E/M visit: 99291 (60), 99292 (30), 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

CPT Code	CPT Descriptor	Global	Work RVU
58550	Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)	10	14 19

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

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

**TIME ESTIMATES (Median)**

New/Revis. CPT Code	Key Reference CPT Code:
<u>58553</u>	<u>58550</u>

Median Pre-Service Time	<u>60</u>	
Median Intra-Service Time	150	
Median Immediate Post-service Time	37.5	
Median Critical Care Time	0	
Median Other Hospital Visit Time	49	
Median Discharge Day Management Time	36	
Median Office Visit Time	<u>46</u>	
Median Total Time	<u>378.5</u>	

Deleted: 90

Deleted: 53

Deleted: 415 5

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.08	3.77
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.08	3.77
Urgency of medical decision making	3.67	3.6

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.88	4.17
Physical effort required	4.72	3.93

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.59	4.00
Outcome depends on the skill and judgement of physician	4.88	4.17
Estimated risk of malpractice suit with poor outcome	4.63	4.13

**INTENSITY/COMPLEXITY MEASURES**

CPT Code	Reference Service 1
----------	---------------------

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.73	3.48
Intra-Service intensity/complexity	4.70	4.06
Post-Service intensity/complexity	3.80	3.58

**ADDITIONAL RATIONALE**

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

**SURVEY METHOD**

At the September 2002 RUC meeting, the RUC research subcommittee approved the revised multiple code survey instrument proposed by the American College of Obstetricians and Gynecologists (ACOG).

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey at the November 2002 AAGL annual meeting. Thirty-three surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted the final recommendations.

**PANEL DISCUSSION**

The panel developed the recommendation in the following manner:

1. Reviewing the survey data
2. Comparing the surveyed code (58553) with similar codes
3. Comparing the surveyed value with the interim value

Survey Data – ACOG received thirty-one completed surveys. The panel recommended 20.00 RVW, the survey median. The panel tested the validity of the median surveyed RVW using IWPUT analysis. **Applying the formula to the surveyed code resulted in an IWPUT of .08. The panel concluded that .08 was an appropriate value for this level of service.**

CPT code values: 99232= 1.06; 99231= .64; 99238=1.28; 99213x2= 1.30

$20.00 - \{ 0224(60\text{min}) + 0224(37.5 \text{ min}) + 1.06 + .64 + .1.28 + .1.30\} / 150 \text{ min} = .08 \text{ IWPUT}$

Similar codes – Next the panel compared the surveyed code (5854X2) with similar codes 58150, Total Abdominal Hysterectomy and 58290, Vaginal hysterectomy, for uterus greater than 250 grams. CPT code 58150 is valued at 15.24 RVW and the RUC approved 19.00 RVW for 58290 at the April 2002 meeting. For your reference, a summary of the times for all three codes is listed below.

CPT CODE	58553	58290	58150
RVW	20.00	19.00	15.24
PRE-SERVICE TIME	60	75	60
INTRA SERVICE TIME	150	120	120
IMMEDIATE POST-SERVICE TIME	37.5	30	40
HOSPITAL VISITS TIME	49	60	87

Deleted: 90

DISCHARGE TIME	36	36	36
OFFICE VISIT TIME	46	46	46
TOTAL TIME	378.5	367	389

Deleted: 53  
Deleted: 415 5

The panel agreed that the consistently higher times for 58553 supported the recommendation of 20.00 RVW. These higher times were a reflection of the intensity and complexity of this procedure.

Interim value –The interim value recommended by the RUC in April 2002 was 19.00. The interim data, a fair estimation of physician work was in the end an estimation. The panel agreed that survey data provided strong evidence that 20.00, the survey median, is a fair and reasonable recommendation for physician work for this code.

The panel unanimously supports the recommendation of 20.00 RVW for 58553.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

**FREQUENCY INFORMATION**

How was this service previously reported?

CPT code 58550, Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)

(if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty American Association of Gynecological Laparoscopists (AAGL)

Commonly  
 Sometimes  
 Rarely

Specialty American College of Obstetricians and Gynecologists (ACOG)

Commonly  
 Sometimes  
 Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

**It is estimated that 10-15% of abdominal hysterectomies are now done laparoscopically**

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

**It is unlikely that this procedure will be performed on Medicare patients.**

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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



AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION

---

CPT Code: 58554 Tracking Number: B6 Global Period: 090 Recommended RVW: 22

CPT Descriptor: 58554, Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:**

A 45 year-old G1P1 is evaluated for profound menorrhagia with anemia. Her hematocrit is 25% despite daily iron therapy and treatment with oral contraceptives. On physical examination she has an irregular, mobile 12-14 week size fibroid uterus. Ultrasound confirms multiple uterine fibroids, several of which impinge on the endometrium. After management options are discussed with her, the patient elects a hysterectomy. A laparoscopic assisted vaginal hysterectomy (LAVH) is performed. The patient has a strong history of ovarian cancer in her family and does not desire any more children therefore her tube(s) and ovary(s) are removed.

**Description of Pre-Service Work:**

The preservice work includes performing a comprehensive preoperative medical history, physical exam including a detailed pelvic exam. A physician must dictate a history and physical, including all admission orders. The patient is identified in the preoperative holding area with the appropriate consents. Patient identification is verified. The patient's family is also spoken to. All preoperative documentation is also reviewed at this time. This includes imaging studies, including ultrasounds and associated laboratory data. The physician reviews with the OR personnel the operative instrumentation necessary for the advanced operative laparoscopy. This includes ensuring that the video monitors are in proper working order. The patient is taken to the OR and correctly positioned on the operating table. This includes positioning of the lower extremities to avoid any potential injury. The physician will also position the monitors prior to the beginning of the case.

**Description of Intra-Service Work:**

An exam under anesthesia is performed and compared to preoperative findings. The patient is then prepped and draped in the usual sterile fashion in the dorsal lithotomy position. A Foley catheter is placed to provide intermittent bladder drainage. Next a weighted speculum is placed into the patient's vagina and the anterior lip of the cervix is grasped using a single tooth tenaculum. A Valchev uterine manipulator is placed after the cervix is adequately dilated to accommodate the Valchev manipulator. The weighted speculum is then removed from the patient's vagina.

Next, attention is turned to the abdominal portion of the procedure. The abdomen is tented and Verres needle is inserted. An adequate pneumoperitoneum is achieved and a 10 mm trochar is placed umbilically. The laparoscope is then advanced through this port and a survey of the abdomen is performed to ensure no injury to any vasculature, abdominal or pelvic structures. Next, under laparoscopic guidance, two additional 10 mm trochar ports are placed in the right and left lower quadrant with care to avoid any abdominal wall vasculature. Next, a survey of the abdomen and pelvis are performed noting multiple large fibroids. Based on their large size and position a myomectomy must first be performed to allow safe removal of the uterus transvaginally. The large fibroids are injected with a solution of dilute Pitressin until adequate blanching is noted. Using the harmonic scalpel, the surface of each injected fibroid is incised and excellent hemostasis is achieved. Next, using sharp dissection, each large fibroid is removed from the myometrium using careful sharp dissection. Once removed the fibroids are suture tagged and placed into the posterior cul-de-sac to be removed at the time of the vaginal portion of the hysterectomy. This is repeated until adequate decompression is achieved. The fibroid beds within the myometrium are then cauterized until adequate hemostasis is achieved. Next, once the myomectomy portion of this procedure is complete, attention is turned to the BSO portion of the procedure where the round ligaments bilaterally are clamped, cut and transected. The ureters are inspected bilaterally. Next, infundibular pelvic ligaments are clamped, cauterized and transected. Hemostasis is assured.

Next attention is turned to the vaginal portion of the procedure and the laparoscope is removed and all gas is allowed to exsufflate from the patient's abdomen. The Valchev uterine manipulator is removed and the single tooth tenaculum is repositioned to provide traction. Next, the cervix is circumferentially incised at the cervicovaginal junction in a clockwise fashion. The anterior and posterior cul-de-sacs are entered using careful sharp dissection. Posterior the peritoneum is identified and a figure-of-eight stay suture is placed for hemostasis and securement using Haney clamps, the uterosacral, cardinal and broad ligaments are bilaterally clamped, cut and ligated. Once freed, the uterus is then delivered. All pedicles are inspected to ensure hemostasis. The specimen is then handed off the field. The vaginal portion of the procedure is then considered complete. The peritoneum and vaginal cuff are closed in the usual fashion. Attention is then turned to the abdominal incisions, which, after trochar removal, are closed, in the usual fashion.

**Description of Post-Service Work:**

The patient is accompanied to the recovery room where postoperative orders are written and the operative report is dictated. The patient is evaluated and stabilized. The family is then counseled regarding the results of the procedure and the anticipated convalescence. Once the patient is alert, she too is counseled regarding the outcome of the surgery and the anticipated hospital stay and subsequent convalescence. She is monitored the day of surgery as well as the following day in the hospital. She is discharged in the evening or afternoon of post day #1. She will be followed as an outpatient with approximately two to three office visits during the 90-day global period.

**SURVEY DATA**

<b>Presenter(s):</b>	George Hill, MD, FACOG and Sandra Reed, MD, FACOG				
<b>Specialty(s):</b>	American College of Obstetricians and Gynecologists (ACOG)				
<b>CPT Code:</b>	58554, Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)				
<b>Sample Size:</b>	70	<b>Resp n:</b>	34	<b>Resp %:</b>	46%
<b>Sample Type:</b>	Survey was distributed at the American Association of Gynecological Laparoscopists (AAGL) annual meeting.				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	14.19	19.25	22.00	24.00	30.00
<b>Pre-Service Time: (day preceding procedure)</b>	5	30	30	60	120
<b>Pre-Service Time: (day of procedure)</b>	25	30	30	51.25	60
<b>Intra-Service Time:</b>	15	148.75	167.5	210	240
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	37.5				
<b>Critical Care time/visit(s):</b>	0				
<b>Other Hospital time/visit(s):</b>	49	99232/1 and 99231-1			
<b>Discharge Day Mgmt:</b>	36	99238/1			
<b>Office time/visit(s):</b>	61	99213/2 and 99212/1			

Deleted: 45  
Deleted: 45

\*Physician standard total minutes per E/M visit: 99291 (60), 99292 (30), 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15), 99211 (7).

**KEY REFERENCE SERVICE:**

CPT Code	CPT Descriptor	Global	Work RVU
58550	Laparoscopy, surgical, with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)	10	14.19

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

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

**TIME ESTIMATES (Median)**

New/Revis. CPT Code	Key Reference CPT Code:
<u>58554</u>	<u>58550</u>

Median Pre-Service Time	60	
Median Intra-Service Time	167.5	
Median Immediate Post-service Time	37.5	
Median Critical Care Time	0	
Median Other Hospital Visit Time	49	
Median Discharge Day Management Time	36	
Median Office Visit Time	61	
Median Total Time	411	

Deleted: 90

Deleted: 441

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.11	3.74
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.11	3.74
Urgency of medical decision making	3.77	3.61

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.88	4.13
Physical effort required	4.76	4.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.70	4.03
Outcome depends on the skill and judgement of physician	4.88	4.16
Estimated risk of malpractice suit with poor outcome	4.61	4.13

**INTENSITY/COMPLEXITY MEASURES**

CPT Code	Reference Service 1
----------	---------------------

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.89	3.48
Intra-Service intensity/complexity	4.80	4.06
Post-Service intensity/complexity	4.05	3.61

**ADDITIONAL RATIONALE**

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

**SURVEY METHOD**

At the September 2002 RUC meeting, the RUC research subcommittee approved the revised multiple code survey instrument proposed by the American College of Obstetricians and Gynecologists (ACOG).

ACOG in collaboration with the American Association of Gynecological Laparoscopists (AAGL) disseminated the RUC survey at the November 2002 AAGL annual meeting. Thirty-four surveys were returned to ACOG via mail and fax. ACOG staff summarized the data. A panel of physicians from ACOG and AAGL reviewed the results and drafted the final recommendations.

**PANEL DISCUSSION**

The panel developed the recommendation in the following manner:

1. Reviewing the survey data using IWPUT analysis
2. Reviewing survey data using the building block approach

IWPUT analysis— ACOG received thirty-four completed surveys. The median RVW from the data was 22.00. The panel tested the validity of the median surveyed RVW using IWPUT analysis.  
CPT code values: 99232= 1.06; 99231= .64; 99238=1.28; 99213= .67; 99212= .45

$22.00 - \{ 0.224(90\text{min}) + .0224(37.5 \text{ min}) + 1.06 + .64 + .1.28 + .67 + .67 + .45 \} / 167.5\text{min} = .09 \text{ IWPUT}$

Applying the formula to the surveyed code resulted in an IWPUT of .09. The panel discussed the .09 intensity was slightly higher than 5855X2. While the panel agreed that complexity and physician skill required of this procedure should result in an intensity around that level but the difference in intensity level from CPT code 5855X2 was a result of minor flaws in a small data sample. Therefore the panel concluded that .09 was an appropriate value for this level of service.

Building block approach – The panel then used the building block approach to validate the recommendation and to identify the appropriate value for removal of tube(s) and ovary(s).

CPT code 5855X2, Laparoscopic hysterectomy greater than 250 grams = 20.00 RVUs

CPT code 58661, Laparoscopic removal of tubes and ovary(s) = 11.05

$20.00 + .50(11.05) = 25.50 \text{ RVUs}$

Another method is to compare the difference in similar vaginal procedures.

CPT code 58260 Vaginal hysterectomy = 12.98

CPT code 58262, Vaginal hysterectomy with removal of tubes and ovary(s) = 14.77

14.77 – 12.98 = 1.79

The difference between these two codes is 1.79 RVUs. Similarly the difference in the recommended values for the laparoscopic codes is 2.00 RVUs.

CPT code 58554, Laparoscopic hysterectomy greater than 250 grams with removal of tube(s) and ovary(s) = 22.00

CPT code 5855X2, Laparoscopic hysterectomy greater than 250 grams = 20.00

22.00 – 20.00 = 2.00

The panel agreed that both methods validate the survey median of 22.00 RVW for this code.

The panel concluded discussion of this code by unanimously supporting the recommendation of 22.00 RVW for 58554.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

**FREQUENCY INFORMATION**

How was this service previously reported?

**CPT code 58550, Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)**

(if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty American Association of Gynecological Laparoscopists (AAGL)

     Commonly

Sometimes

     Rarely

Specialty American College of Obstetricians and Gynecologists (ACOG)

     Commonly

     Sometimes

Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

**It is estimated that 10-15% of abdominal hysterectomies are now done laparoscopically**

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

**It is unlikely that this procedure will be performed on Medicare patients.**

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

---

---

	A	B	C	D	E	F	G	H	I	J
1			FAMILY 1							
2			CPT Code - 58550		CPT Code - 58552		CPT Code - 58553		CPT Code - 58554	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Laparoscopy (surge) with vaginal hysterectomy for uterus 250 grams or less		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy for uterus 250 grams or less with removal of tube(s) and/or ovary(s)		Code Descriptor - Laparoscopy (surge) with vaginal hysterectomy for uterus greater than 250 grams		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams with removal of tube(s) and/or ovary(s)	
4	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
5	GLOBAL PERIOD			90		90		90		90
6	TOTAL CLINICAL LABOR TIME		0 0	171 0	0 0	171 0	0 0	144 0	0 0	171 0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		0 0	60 0	0 0	60 0	0 0	60 0	0 0	60 0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		0 0	12 0	0 0	12 0	0 0	12 0	0 0	12 0
9	TOTAL POST-SERV CLINICAL LABOR TIME		0 0	99 0	0 0	99 0	0 0	72 0	0 0	99 0
10	PRE-SERVICE									
11	Start: Following visit when decision for surgery or procedure made									
12	Complete pre-service diagnostic & referral forms			5		5		5		5
13	Coordinate pre-surgery services			20		20		20		20
14	Schedule space and equipment in facility			8		8		8		8
15	Office visit before surgery/procedure Review test and exam results			0		0		0		0
16	Provide pre-service education/obtain consent			20		20		20		20
17	Follow-up phone calls & prescriptions			7		7		7		7
18	Other Clinical Activity (please specify)			0		0		0		0
19	End When patient enters office/facility for surgery/procedure									
20	SERVICE PERIOD									
21	Start: When patient enters office/facility for surgery/procedure									
22	Pre-service services									
23	Review charts			0		0		0		0
24	Greet patient and provide gowning			0		0		0		0
25	Obtain vital signs			0		0		0		0
26	Provide pre-service education/obtain consent			0		0		0		0
27	Prepare room equipment, supplies			0		0		0		0
28	Prepare and position patient/ monitor patient/ set up IV			0		0		0		0
29	Sedate/apply anesthesia			0		0		0		0
30	Intra-service									
31	Assist physician in performing procedure			0		0		0		0
32	Post-Service									
33	Monitor pt. following service/check tubes monitors, drains			0		0		0		0
34	Clean room/equipment by physician staff			0		0		0		0
35	Complete diagnostic forms lab & X-ray requisitions			0		0		0		0
36	Review/read X-ray, lab, and pathology reports			0		0		0		0
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			0		0		0		0
38	Coordination of Care			0		0		0		0
39	Discharge day management 99238 --12 minutes			12		12		12		12
40	99239 --15 minutes			0		0		0		0
41	Other Clinical Activity (please specify)			0		0		0		0
42	End Patient leaves office									
43	POST-SERVICE Period									
44	Start: Patient leaves office/facility									
45	Conduct phone calls/call in prescriptions			0		0		0		0
46	Office visits Greet patient, escort to room provide gowning interval history & vital signs and chart; assemble previous test reports/results, assist physician during exam assist with dressings wound care, suture removal, prepare dx test, prescription I									
47	List Number and Level of Office Visits									
48	99211 16 minutes	16		0		0		0		0
49	99212 27 minutes	27		27		27		27		27
50	99213 36 minutes	36		72		72		72		72
51	99214 53 minutes	53		0		0		0		0
52	99215 63 minutes	63		0		0		0		0
53	Other									
54	Total Office Visit Time		0	99	0	99	0	72	0	99
55	Other Activity (please specify)									
56	End with last office visit before end of global period									

	A	B	C	D	E	F	G	H	I	J
2			CPT Code - 58550		CPT Code - 58552		CPT Code - 58553		CPT Code - 58554	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less, with removal of tubal(s) and/or ovary(s)		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams		Code Descriptor - Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams, with removal of tubal(s) and/or ovary(s)	
4	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
57	MEDICAL SUPPLIES									
58	OB/GYN Supply Package A			3		3		2		3
59	OB/GYN Supply Package B			3		3		2		3
60	Drape sheet	1106		3		3		2		3
61										
62										
63										
64										
65	Equipment									
66	power table	E11003		99		99		80		99
67	fiberoptic exam light	E11006		99		99		80		99
68										
69										
70										
71										

	A	B	C	D	E	F	G	H
1			FAMILY 1					
2			CPT Code - 58545		CPT Code - 58546			
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus, excision of 1-4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas		Code Descriptor - Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams			
4	LOCATION		In Office	Out Office	In Office	Out Office		
5	GLOBAL PERIOD			90		90		
6	TOTAL CLINICAL LABOR TIME		0.0	144.0	0.0	144.0		
7	TOTAL PRE-SERV CLINICAL LABOR TIME		0.0	60.0	0.0	60.0		
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		0.0	12.0	0.0	12.0		
9	TOTAL POST-SERV CLINICAL LABOR TIME		0.0	72.0	0.0	72.0		
10	<b>PRE-SERVICE</b>							
11	Start: Following visit when decision for surgery or procedure made							
12	Complete pre-service diagnostic & referral forms			5		5		
13	Coordinate pre-surgery services			20		20		
14	Schedule space and equipment in facility			8		8		
15	Office visit before surgery/procedure Review test and exam results			0		0		
16	Provide pre-service education/obtain consent			20		20		
17	Follow-up phone calls & prescriptions			7		7		
18	Other Clinical Activity (please specify)			0		0		
19	End: When patient enters office/facility for surgery/procedure							
20	<b>SERVICE PERIOD</b>							
21	Start: When patient enters office/facility for surgery/procedure							
22	Pre-service services							
23	Review charts			0		0		
24	Greet patient and provide gowning			0		0		
25	Obtain vital signs			0		0		
26	Provide pre-service education/obtain consent			0		0		
27	Prepare room, equipment, supplies			0		0		
28	Prepare and position patient/ monitor patient/ set up IV			0		0		
29	Sedate/apply anesthesia			0		0		
30	Intra-service							
31	Assist physician in performing procedure			0		0		
32	Post-Service							
33	Monitor pt following service/check tubes, monitors, drains			0		0		
34	Clean room/equipment by physician staff			0		0		
35	Complete diagnostic forms, lab & X-ray requisitions			0		0		
36	Review/read X-ray, lab, and pathology reports			0		0		
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			0		0		
38	Coordination of Care					0		
39	Discharge day management 99238 --12 minutes 99239 --15 minutes			12		12		
40	Other Clinical Activity (please specify)			0		0		
41	End: Patient leaves office							
42	<b>POST-SERVICE Period</b>							
43	Start: Patient leaves office/facility							
44	Conduct phone calls/call in prescriptions			0		0		
45	Office visits Greet patient, escort to room, provide gowning, interval history & vital signs and chart, assemble previous test reports/results, assist physician during exam, assist with dressings, wound care, suture removal, prepare dx test, prescription forms, post service education, instruction, counseling, clean room/equip, check supplies, coordinate home or outpatient care							
46	List Number and Level of Office Visits							
47	99211 16 minutes	16		0		0		
48	99212 27 minutes	27		0		0		
49	99213 36 minutes	36		72		72		
50	99214 53 minutes	53		0		0		
51	99215 63 minutes	63		0		0		
52	Other							
53								
54	Total Office Visit Time		0	72	0	72		
55	Other Activity (please specify)							
56	End: with last office visit before end of global period							

	A	B	C	D	E	F	G	H
2			CPT Code - 58545		CPT Code - 58546			
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor - Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; excision of 1-4 intramural myomas with total weight of 250 grams or less and/or removal of surface myomas.		Code Descriptor - Laparoscopy, surgical, myomectomy, excision of fibroid tumor(s) of uterus; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 grams.			
4	LOCATION		In Office	Out Office	In Office	Out Office		
57	MEDICAL SUPPLIES							
58	OB/GYN Supply Package A			2		2		
59	OB/GYN Supply Package B			2		2		
60	Drape sheet	1106		2		2		
61								
62								
63								
64								
65	Equipment							
66	power table	E11003		80		106		
67	fiberoptic exam light	E11006		80		106		
68								
69								
70								
71								

	A	B	I	J	K	L	M	N
1								
2								
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE						
4	LOCATION							
5	GLOBAL PERIOD							
6	TOTAL CLINICAL LABOR TIME							
7	TOTAL PRE-SERV CLINICAL LABOR TIME							
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME							
9	TOTAL POST-SERV CLINICAL LABOR TIME							
10	<b>PRE-SERVICE</b>							
11	Start: Following visit when decision for surgery or procedure made							
12	Complete pre-service diagnostic & referral forms							
13	Coordinate pre-surgery services							
14	Schedule space and equipment in facility							
15	Office visit before surgery/procedure Review test and exam results							
16	Provide pre-service education/obtain consent							
17	Follow-up phone calls & prescriptions							
18	Other Clinical Activity (please specify)							
19	End: When patient enters office/facility for surgery/procedure							
20	<b>SERVICE PERIOD</b>							
21	Start: When patient enters office/facility for surgery/procedure							
22	Pre-service services							
23	Review charts							
24	Greet patient and provide gowning							
25	Obtain vital signs							
26	Provide pre-service education/obtain consent							
27	Prepare room, equipment, supplies							
28	Prepare and position patient/ monitor patient/ set up IV							
29	Sedate/apply anesthesia							
30	Intra-service							
31	Assist physician in performing procedure							
32	Post-Service							
33	Monitor pt following service/check tubes, monitors, drains							
34	Clean room/equipment by physician staff							
35	Complete diagnostic forms, lab & X-ray requisitions							
36	Review/read X-ray, lab, and pathology reports							
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions							
38	Coordination of Care							
39	Discharge day management 99238 --12 minutes 99239 --15 minutes							
40	Other Clinical Activity (please specify)							
41	End: Patient leaves office							
42	<b>POST-SERVICE Period</b>							
43	Start: Patient leaves office/facility							
44	Conduct phone calls/call in prescriptions							
45	Office visits Greet patient, escort to room, provide gowning, interval history & vital signs and chart, assemble previous test reports/results, assist physician during exam, assist with dressings, wound care, suture removal, prepare dx test, prescription forms, post service education, instruction, counseling, clean room/equip, check supplies, coordinate home or outpatient care							
46	List Number and Level of Office Visits							
47	99211 16 minutes	16						
48	99212 27 minutes	27						
49	99213 36 minutes	36						
50	99214 53 minutes	53						
51	99215 63 minutes	63						
52	Other							
53								
54	Total Office Visit Time							
55	Other Activity (please specify)							
56	End with last office visit before end of global period							
57	<b>MEDICAL SUPPLIES</b>							
58	OB/GYN Supply Package A							

	A	B	I	J	K	L	M	N
2								
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE						
4	LOCATION							
59	OB/GYN Supply Package B							
60	Drape sheet	1106						
61								
62								
63								
64								
65	<b>Equipment</b>							
66	power table	E11003						
67	fiberoptic exam light	E11006						
68								
69								
70								
71								

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

September 2002

**Minimally Invasive Repair of Pectus Excavatum**

These codes were developed to describe a new minimally invasive technique in reconstructive repair of the pectus excavatum or carinatum.

The specialty society and the RUC request that the minimally invasive approach for reconstructive repair of pectus excavatum or carinatum (CPT codes 21742 and 21743) remain carrier price until the specialty is able to acquire data for these services.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
σ21740	AN1	Reconstructive repair of pectus excavatum or carinatum; <u>open</u>	090	16.50 (no change)
λ21742	AN2	minimally invasive approach (Nuss procedure) without thoracoscopy	090	Carrier Priced
λ21743	AN3	minimally invasive approach (Nuss procedure) with thoracoscopy	090	Carrier Priced

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE  
SUMMARY OF RECOMMENDATIONS

September 2002

**Refilling of Implantable Infusion Pumps**

CPT created a new code 95990, *Refilling and maintenance of implantable pump or reservoir for drug delivery; spinal (intrathecal, epidural) or brain (intraventricular)*. Although some providers were reporting this service with CPT code 96530, *Refilling and maintenance of an implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)* the specialty indicated that this code was inappropriately utilized. The physician services that are described by CPT code 95990 should have been previously reported using code 64999, *Unlisted procedure, nervous system*. Code 95990 describes a service requiring direct physician involvement and therefore, the service should have an assigned work value. The RUC clarified with the presenters that the physician and a registered nurse typically provide the service together. With this in mind, the RUC recommends that code 95990 include an editorial note to indicate that the physician is always present during the performance of this service.

A coalition of several specialties, including pain medicine, anesthesiology, neurosurgery, and spine surgery reviewed and surveyed the new CPT code 95990. A survey median of 1.82 was collected from 67 physicians, who indicated a pre-service time of 10 minutes, an intra-service time of 20 minutes, and a post-service time of 10 minutes. After the review of survey responses, the societies felt that the median survey value (1.82) was too high, therefore, the specialty society recommended 1.38, which is between the 25<sup>th</sup> percentile (1.11) and the median. The RUC did not agree that a work RVU of 1.38 was appropriate.

Although this code is billed often with an E/M code, the RUC understands that the survey respondents were surveyed for the specific work of the service only. The group identified relatively similar services for which they could compare work, time, and intensity. The RUC focused its comparison on two codes, 67500 *Retrobulbar injection; medication (separate procedure, does not include supply of medication)* (Work RVU = 0.79) and 62252 *Reprogramming of programmable cerebrospinal shunt* (Work RVU = 0.74). The RUC surveyed the physician time for the 62252 is 15 minutes pre-service time, 20 minutes intra-service time, and 10 minutes post-service time. This was comparable to the time for 95990 and the RUC agreed that 62252 serves as a good cross comparison to this new code. **The RUC recommends the work RVU of 0.77 for CPT code 95990.**

**Physician Time**

For code 95990, the RUC agreed that the 15 minutes pre-service time and the 20 minutes post-service time were reasonable. However, as the RN was also involved in the provision of the service, the RUC was concerned that the physician time in the post-operative period was too high, and the presenters agreed. The RUC recommends that the post-operative physician time should be reduced from 10 minutes to 7 minutes to eliminate this duplication of work.

**Practice Expense**

The RUC reviewed in detail the practice expense inputs for code 95990, and understood that with the types of drugs being administered, a RN staff type was appropriate for all the clinical staff activities except for time for cleaning the room. The RUC members agreed with the time distributions among the various clinical activities, as well as the medical supplies and equipment typically used for the service. The practice expense recommendations presented by the specialty society were accepted by the RUC.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
λ 95990	AJ1	Refilling and maintenance of implantable pump or reservoir for drug delivery; spinal (intrathecal, epidural) or brain (intraventricular) <u>(For analysis and/or reprogramming of implantable infusion pump, see 62367-62368)</u> <u>(For refill and maintenance of implanted infusion pump or reservoir for systemic drug therapy (eg, chemotherapy or insulin, use 96530)</u>	XXX	0.77
σ96530	AJ2	Refilling and maintenance of an implantable pump or reservoir <u>for drug delivery, systemic (eg, intravenous, intra-arterial)</u>  <u>(For refilling and maintenance of an implantable infusion pump for spinal or brain drug infusion, use 95990)</u>	XXX	0.00 (No Change)

### **Other Related Notes in CPT**

- 36533 *Insertion of implantable venous access device, with or without subcutaneous reservoir*  
(For refilling and maintenance of an implantable pump or reservoir ~~venous access device reservoir~~, for intravenous or intra-arterial drug delivery, use 96530)
- 62350 *Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy*
- 62351 *with laminectomy*  
(For refilling and maintenance of an implantable ~~venous access device reservoir~~, infusion pump for spinal or brain drug therapy use 95990 96530)
- 62367 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming*
- 62368 *with reprogramming*  
(~~To report implantable pump or reservoir refill~~, For refilling and maintenance of an implantable infusion pump for spinal or brain drug therapy, use 96530 95990)
- 90788 *Intramuscular injection of antibiotic (specify)*
- (90790-90796 has been deleted. To report, see 95990, 96408-96414, 96420-96425, 96440, 96450, 96530, 96545, 96549)  
96408 *Chemotherapy administration, intralesional; up to and including 7 lesions*
- 96410 *infusion technique, up to one hour*
- 96412 *infusion technique, one to 8 hours, each additional hour (List separately in addition to code for primary procedure)*  
(Use 96412 in conjunction with code 96410)
- 96414 *infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump*
- (For ~~pump or reservoir-refilling and maintenance of an implantable infusion pump or reservoir~~ for intravenous or intra-arterial drug delivery, see 96520, 96530)
- 96420 *Chemotherapy administration, intra-arterial; push*
- 96425 *infusion technique, initiation or prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump*
- (For ~~implanted pump or reservoir-refilling and maintenance of an implantable infusion pump or reservoir~~ for intravenous or intra-arterial drug delivery, see 96520, 96530)

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

---

CPT Code: 95990 Tracking Number: AJ1 Global Period: XXX RUC Recommended RVW: 1.38  
0.77

**CPT Descriptor:**

Refilling and maintenance of implantable pump or reservoir for drug delivery; spinal (intrathecal, epidural) or brain (intraventricular)

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** The typical patient is a 45 year old female with severe cancer-related pain. She has failed to obtain adequate pain relief without intolerable side effects from multiple trials of systemic medications, both narcotic and non-narcotic, as well as various blocks and injections. It is judged that the pain would not be improved by any further surgical resection, radiation therapy, and/or chemotherapy. A trial of an intrathecal infusion of morphine gave 80% pain relief at low dose rates. A permanent implanted subcutaneous programmable infusion pump was placed as well as an implanted intrathecal infusion catheter for a long-term intrathecal infusion of narcotic.

**Description of Pre-Service Work:** The solution to be injected into the pump/reservoir is ordered by the physician from the appropriate pharmacy. The order is to specify the name of the drug, the volume of the solution, the concentration of the solution, and the nature of the drug (preservative-free).

**Description of Intra-Service Work:** The center of the implanted subcutaneous continuous infusion pump or reservoir is palpated and identified. This center point is marked on the skin. The entire area over the pump or reservoir is then carefully prepped with iodine or alcohol. Throughout all this procedure, sterile technique is meticulous to prevent infection in the infusion solution, which would cause life-threatening meningitis. A special pump refill kit is then opened and an extra 20 cc syringe, 20 gauge needle, and 4x4 sponge added to the kit. Sterile gloves are then donned and a sterile drape with an open center area is taken from the refill kit and placed over the pump, being sure that all skin in the exposed center area has been prepped with iodine or alcohol.

Using sterile technique, the previously prepared drug to be injected into the pump or reservoir is then drawn from its transport or commercially-prepared vial into one of the 20 gauge needles. The solution's container is checked to be sure that the drug, the drug volume, and the drug's concentration are all correct according to what was ordered.

The 22g Huber needle in the refill kit is then attached to the overpressurization T-tubing in the kit and the tubing's stopcock closed. The Huber needle is then carefully, under sterile conditions, punctured through the skin over the center of the pump or reservoir. The needle is advanced and probed to find the actual center of the pump or reservoir and then the needle is advanced through the injection septum of the pump or reservoir to the proper depth. Once the needle has been positioned in the pump/reservoir, an empty 20 cc (or other appropriate volume) syringe is attached to the needle's tubing, stopcock opened, and the pump/reservoir emptied of its contents. The volume of the solution removed from the pump/reservoir is measured and checked against the medical records and/or pump status printout to be sure that the entire volume of the pump/reservoir has been removed. Failure to remove all the fluid can result in overfilling the pump/reservoir with the new solution and damage to the pump/reservoir or even pump/reservoir malfunction causing a potentially life-threatening intrathecal overdose of narcotic or baclofen to the patient. The stopcock is closed, the syringe removed, the syringe containing the new solution attached to the tubing, and the stopcock re-opened. The solution is then slowly over several minutes, injected into the pump/reservoir. It is double-checked that the correct volume has been injected into the pump/reservoir and then any possible overpressurization of the pump/reservoir is checked by turning the stopcock to allow pump solution to flow into the tubing's T-piece. This step of checking to avoid injecting too much solution and checking for overpressurization are critical to prevent overfilling the pump, which again could cause pump malfunction and/or sudden intrathecal overdosage of the drug that could be life-threatening.

**Description of Post-Service Work:** Once the T-tubing overpressurization check has been completed, the needle and tubing assembly are withdrawn from the pump and the skin. A sterile sponge is used to dry the skin and seal the puncture area. A band-aid is placed over the puncture spot. Excess iodine or alcohol is wiped from the surrounding skin. The contaminated needles, tubing, syringes, sponge, and gloves are then properly disposed.

---

**SURVEY DATA:**

Presenter(s) Norman Cohen, MD, American Society of Anesthesiologists, Samuel Hassenbusch, MD, PHD, American Academy of Pain Medicine, Charles Mick, MD, North American Spine Society

Specialty(s): American Academy of Pain Medicine, American Society of Anesthesia, American Association of Neurological Surgeons, Congress of Neurological Surgeons

Sample Size: 4791\*\* **Responses: 67** Response Rate: (%): 1.4% Median RVW: 1.82

Type of Sample (Circle One): random, panel, **convenience**. Explanation of sample size: \*\*

Surveys were sent out to all members of American Neuromodulation Society, the Pain Section of neurosurgery (AANS-CNS), and to implantable interventional pain medicine physicians of AAPM. Members of NASS and ASA were also notified of this survey on their web sites. It was difficult to determine the exact number of respondents that actually looked at the web site survey from those numbers. We used the total membership numbers because of this which make the response rate look very deflated.

25th Percentile RVW: 1.11 75th Percentile RVW: 2.00 Low: 0 High: 8.42

Median Pre-Service Time: 10 Median Intra-Service Time: 20

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 30 Low: 3 High: 90

Median Post-Service Time: 40 7

Level of Service by CPT Code N/A

Total Time (List CPT Code & # of Visits)

Immediate Post Service Time: N/A

Critical Care: N/A

Other Hospital Visits: N/A

Discharge Day Mgmt.: N/A

Office Visits: N/A

---

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>RVW</u>
62368	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion ( includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming	0.75

---

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

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

<b>TIME ESTIMATES (Median)</b>	<b>New/Revis. CPT Code: 95990</b>	<b>Key Reference CPT Code: 62368</b>
Median Pre-Time	10	0
Median Intra-Time	20	30
Median Immediate Post-service Time	10-7	0
Median of Aggregate Critical Care Times	N/A	
Median of Aggregate Other Hospital Visit Times	N/A	
Median Discharge Day Management Time	N/A	
Median of Aggregate Office Visit Times	N/A	

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.55	2.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.31	1.86
Urgency of medical decision making	3.25	2.00

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.36	2.29
Physical effort required	2.61	2.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.75	2.00
Outcome depends on the skill and judgement of physician	3.70	2.71
Estimated risk of malpractice suit with poor outcome	4.00	2.57

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference  
Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.19	2.50
Intra-Service intensity/complexity	3.48	3.33

## ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation.

The American Academy of Pain Medicine sent out surveys including four different societies and asked the members to fill out the RVS and PE surveys. The data was compiled and analyzed. The final results were presented to a committee of the Academy of Pain Medicine in a conference call. The data was discussed in great detail and a consensus was established as to what data to present to the AMA RVS, (RUC), committee. This data appears on this summary form.

The Recommended RVW of 1.38 was chosen based upon a building block methodology. Using existing times and an IWPUT of 0.047 produces an RVW of 1.38. IWPUT for some related codes are: 62284 = .047, 62270 = .042 and 62272 = .052. RVWs for these related codes are: 62284 - 1.18 RVWs, 62270 - 0.88 RVWs, 62272 - 1.01 RVWs. We believe that the 95990 survey median RVW of 1.82 is too high. The statistics show a high value of 8.42 with a 75<sup>th</sup> percentile of 2.0 so the curve is skewed to the high end which would drive the median higher than a normal distribution.

---

**FREQUENCY INFORMATION**

How was this service previously reported? 96530 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty AAPM  Commonly  Sometimes  Rarely

Specialty ASA  Commonly  Sometimes  Rarely

Specialty AANS-CNS  Commonly  Sometimes  Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AAPM Frequency 15,600

Specialty ASA Frequency 23,250

Specialty AANS-CNS Frequency 8,400

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

Specialty AAPM Frequency 10,400

Specialty ASA Frequency 15,500

Specialty AANS-CNS Frequency 5,600

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

---

**AMA/Specialty Society Update Process  
RUC Summary of Recommendation  
XXX Global Period  
In Office Direct Inputs**

Sample Size: 4791      Response Rate: 1.4 (%)      Global Period: XXX

Tracking Number AJ1      Reference Code 1: 62638 62368      Reference Code 2: 96530

Geographic Practice Setting %: Rural 10%    Suburban 35%    Urban 55%

Type of Practice %:    27% Solo Practice  
                              39% Single Specialty Group  
                              10% Multispecialty Group  
                              24% Medical School Faculty Practice Plan

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

Surveys were sent out to members of the North American Spine Society and American Society of Anesthesiologists web site. Surveys were sent to American Neuromodulation Society, American Academy of Pain Medicine, and Pain Section of American Association of Neurological Surgeons-Congress of Neurological Surgeons by either fax or email. The data were collated and analyzed. The data were then presented to the American Academy of Pain Medicine, American Society of Anesthesiologists, and American Association of Neurological Surgeons-Congress of Neurological Surgeons, and The North American Spine Society who called together their coding/socio-economic committees to further disseminate the information. A multi-specialty RVS practice expense committee, consisting of practitioners involved in both in-office and out-of-office interventional pain management in multiple practice settings in widespread geographic areas was utilized. The committees after much discussion and thought came to a consensus on the final data to present on this summary form and to the RUC.

The practice expense direct inputs for clinical staff, supplies and equipment for this code have been determined with the assumption that typically a separate E/M visit will also be coded on the same day. We have deleted necessary clinical staff activities such as obtaining vital signs and greeting and gowning of the patient that are captured under the E/M code to avoid duplication. Insurance refusal to cover the same day E/M visit would result in under-valuation of this code.

Please describe the clinical activities of your staff:

**Pre Service period** – An RN handles the order for the patient specific, custom formulated narcotic mixture. The RN receives the medication, confirms the correct formulation, records receiving the medication and assures safe storage until the procedure. When the medication has arrived the patient is contacted, instructions are reviewed and the pump refill is scheduled. We believe the recently developed 0-10 day global pre-service time for in office procedures of 18 minutes reflects these activities for the first pump refill. When the patient returns for repeat refills many of the staff activities remain constant, however the 7 minutes allotted by the PEAC for pre-service education/consent is less after the patient becomes familiar with the procedure.

**Specialty Society('s)American Academy of Pain Medicine**

We have accordingly decreased the final pre-service recommendation by 3 minutes (from 18 minutes to 15 minutes).

**Service period-** No time has been requested for greeting and gowning of the patient or for obtaining vital signs because this is captured by the E/M visit which typically occurs at the same time. An RN reviews the chart, prepares the room, equipment and supplies and positions the patient. The RN then assists the physician during the pump refill. We have recommended 10 minutes of time to assist the physician (one-half of the intra-service MD time). The patient is then monitored for approximately 30 minutes to assure that none of the narcotic has leaked from the pump into the subcutaneous tissue. We have recommended 10 minutes of RN monitoring time (one-third of the total) to account for multi-tasking.

**Post Service period –** One phone call is typically made following the refill for pump specific follow-up. Because an E/M visit will be coded at the same time and that code includes a follow-up phone call we have not included a separate call to avoid duplication.

**Supplies:** In-office supplies are fairly standard and include CPEP recommended supplies and supplies particular to this procedure. A standard E/M package is utilized but is accounted for in the E/M visit.

**Equipment:** A power exam table is utilized for the procedure.

Pre-Service Clinical Labor Activities:

Coordinate pre-procedure services (Check pump drug ordering is correct, Call in prescription/order, Obtain drug(s), Store drug(s) in safe location

Intra-Service Clinical Labor Activities:

Review charts  
Greet patient and provide gowning  
Obtain vital signs  
Provide preservice education, obtain consent  
Prepare room, equipment, supplies  
Prepare and position patient, monitor patient

*Post Procedure:*

Monitor pt. following service/check tubes, monitors, drains  
Clean room/equipment by physician staff  
Check dressings & wound/ home care instructions/coordinate office visits/prescriptions

**Post-Service Clinical Activities**

Conduct phone calls/call in prescriptions

HCFA's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
1033	RN	15	32		0.422/min
1130	RN/LPN/MA		3		0.317/min

Specialty Society('s)American Academy of Pain Medicine

\* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, provide full description, estimated cost, and cost source.

HCFA's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
NEW	Medtronic refill kit/ Model 8551 SynchroMed refill kit	1 kit		28.00 each
14005	Sterile pair of gloves	1 pr	Box	0.89
11306	Surgical mask	1	Case	0.30
91409	20 cc syringes	2	Case	1.24 each .62
52305	Betadine pre sticks	1 pkg	Case	0.44
31508	4x4 sponge/gauze	1 pack	Case	1.47
31502	Band aid	1	Box	0.05
91402	20-gauge needle	2	Box	0.24
11102	Chuck pad	1	Case	0.05

\* From HCFA's Labor, Medical Supply, and Equipment List for year 2001. If not listed, provide full description, estimated cost, and cost source.

HCFA's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E11003	Power table		27		

**Type of Service: Evaluation/Management Services or Diagnostic Tests  
XXX Global Period**

**TYPE OF SERVICE: Surgical Procedures  
000 Global Period**

**SITE OF SERVICE: In-OFFICE**

**Clinical Services**

**Minutes**

**Staff Type – Circle**

**Pre-Service Period**

*Start: Following visit when decision for surgery or procedure made*

Complete pre-service diagnostic & referral forms	5	<u>RN</u>
Coordinate pre-procedure services	3	<u>RN</u>
Office visit before surgery/procedure Review test and exam results	0	
Provide pre-service education/obtain consent	4	<u>RN</u>
Follow-up phone calls & prescriptions	3	<u>RN</u>
Other Clinical Activity (please specify)	0	

*End: When patient enters office for surgery/procedure*

**Service Period**

*Start: When patient enters office for surgery/procedure  
Pre-service services*

Review charts	3	<u>RN</u>
Greet patient and provide gowning	0	
Obtain vital signs	0	
Provide pre-service education/obtain consent	0	
Prepare room, equipment, supplies	2	<u>RN</u>
Prepare and position patient/ monitor patient	2	<u>RN</u>
Sedate/apply anesthesia	0	
<i>Intra-service</i>		
Assist physician in performing procedure	10	<u>RN</u>
Monitor pt. following service/check tubes, monitors, drains	10	<u>RN</u>
Clean room/equipment by physician staff	3	<u>RN/LPN/MA</u>
Complete diagnostic forms, lab & X-ray requisitions	0	
Review/read X-ray, lab, and pathology reports	0	

Check dressings & wound/ home care instructions/coordinate office visits/prescriptions 5 RN

Other Clinical Activity (please specify)  
*End: Patient leaves office*

**Post-Service**

Post-Op Visit (99212 x1) 0  
Phone calls/call in prescriptions 0

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

September 2002

**Therapeutic Apheresis**

New CPT codes 36511-36516 replace codes 36520 *Therapeutic apheresis; plasma and/or cell exchange* (Work RVU = 1.74) and code 35521 *Therapeutic apheresis; with extracorporeal affinity column adsorption and plasma reinfusion* (Work RVU = 1.74) to allow reporting for the different types of therapeutic apheresis that are now performed. This also allows for better recording of the frequency of the different therapeutic apheresis procedures. Previously reported codes 36520 and 36521 were too vague to code for all the different apheresis procedures now in existence.

At the April 2002 RUC meeting, the RUC reviewed these new CPT codes and determined that the specialty should coordinate a survey process to collect data to present at the September 2002 meeting. The RUC recommended interim values of 1.74 for each of the therapeutic apheresis services, which is the value cross-walked from current codes 36521 and 36520.

In summer 2002, the specialty coordinated its survey efforts with subspecialty organizations and other specialties (eg, nephrology and rheumatology) and completed a survey of the work relative values for these services. The American Society of Hematology (ASH) also contacted the manufacturer associated with the supplies and equipment for this service to best determine the institutions that are currently performing this service. Data was accumulated and reviewed for presentation to the RUC in September.

The RUC reviewed the survey data and confirmed that the survey respondents understood that these six new CPT codes were assigned a global period of 000, and that all services typically provided to a patient on the day of the apheresis procedure are considered to be part of that procedure. It was understood that evaluation and management services typically provided to the patient on the day of the apheresis service would be included in the valuation of this service. Thus a separate visit code, such as an office or outpatient visit or subsequent hospital care, should generally not be reported by the physician on the day in which he/she reports an apheresis service. Separate reporting is permitted, however, for a consultation, initial hospital care or discharge day management, when these separately identifiable services are performed.

The specialty indicated that most typically two physicians are involved in the treatment of these patients, one treating the disease and one providing the apheresis treatment. The typical patient receives numerous treatments. Therefore, the majority of the services are performed on a date when a consultation service would not be performed or reported.

The RUC reviewed and discussed whether it was appropriate for all six codes to be valued the same. The RUC had initially requested the survey following the April 2002 RUC meeting, as it appeared that there should be a differentiation in the work values between these codes. The specialty argued that the specialty is unable to identify any differentiation in work between these services, at this time. The specialty indicated that it was a priority to differentiate the coding to capture the facility expense related to these services. The RUC concluded that the work relative value should be consistent between the first five codes, 36511-36515 (U1-U5).

However, the RUC was not compelled that the work has changed for these services and recommends the existing relative value of 36520 (1.74), rather than the specialty recommendation of 2.10. The RUC also recommended that the new survey time be incorporated into the RUC database for these five services. The RUC also agreed that the physician time for codes 36511 – 36515 (U1-U5) should be consistent and recommends the survey time of 40 minutes pre-time, 20 minutes intra-time, and 15 minutes post-time.

The RUC, however, noted that the work relative value of 1.74 was too high for code 36516 (U6). The RUC recommends that CPT code 90935 *Hemodialysis procedure with single physician evaluation* (work RVU = 1.22), be used as a crosswalk. The intra-service time and the types of services are similar, and there is relative proportionality with the time difference between U6 and U1-U5. **The RUC recommends that the specialty request that CPT change the descriptor to specify “with physician evaluation.”**

**The RUC recommends the following work relative value units for these services:**

<b>36511</b>	<b>U1</b>	<b>Therapeutic apheresis; for white blood cells</b>	<b>1.74</b>
<b>36512</b>	<b>U2</b>	<b>for red blood cells</b>	<b>1.74</b>
<b>36513</b>	<b>U3</b>	<b>for platelets</b>	<b>1.74</b>
<b>36514</b>	<b>U4</b>	<b>for plasma pheresis</b>	<b>1.74</b>
<b>36515</b>	<b>U5</b>	<b>with extracorporeal immunoadsorption and plasma reinfusion</b>	<b>1.74</b>
<b>36516</b>	<b>U6</b>	<b>with extracorpeal selective adsorption or selective filtration and plasma reinfusion</b>	<b>1.22</b>

**Practice Expense Inputs:**

The specialty had determined these services are performed more than 95% in the facility setting and the RUC agreed that they should not be priced in the non-facility setting at this time. Therefore, there are no direct practice expense input recommendations.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Rec.
● 36511	U1	Therapeutic apheresis; for white blood cells	000	1.74
● 36512	U2	for red blood cells	000	1.74
● 36513	U3	for platelets	000	1.74
● 36514	U4	for plasma pheresis	000	1.74
● 36515	U5	with extracorporeal immunoadsorption and plasma reinfusion	000	1.74
● 36516	U6	with extracorporeal selective adsorption or selective filtration and plasma reinfusion	000	1.22
36520(D)		<del>Therapeutic apheresis; plasma and/or cell exchange</del> <u>(36520 has been deleted. To report use 36511-36512)</u>	000	N/A
36521(D)		<del>with extracorporeal affinity column adsorption and plasma reinfusion</del> <u>(36521 has been deleted. To report, use 36516)</u>	000	N/A



# THE AMERICAN SOCIETY OF HEMATOLOGY

1900 M Street, NW, Suite 200, Washington, DC 20036 ph 202.776.0544 fax 202 776 0545 e-mail ASH@hematology.org

2002

**President**

Robert I Handin, M D  
Executive Vice Chairman, Department of  
Co-Director, Hematology Division  
Brigham & Women's Hospital  
75 Francis Street  
Boston, MA 02115-6110  
ph 617 732 5840  
fax 617 732 5706  
rhandin@partners.org

**President-Elect**

Ronald Hoffman, M D  
University of Illinois - Chicago  
College of Medicine  
900 S Ashland Ave., M/C 734  
Chicago, IL 60607-4004  
ph 312 413 9308  
fax 312 413 7963  
ronhoff@uic.edu

**Vice President**

Stanley L Schrier, M D  
Stanford University School of Medicine  
CCSR, Room 1155  
Stanford, CA 94305-5156  
ph 650 723 8688  
fax 650 736 0974  
sschrier@leland.stanford.edu

**Secretary**

Nancy Berliner, M D  
University School of Medicine  
of Hematology, WWW428  
3 Cedar Street  
New Haven, CT 06510  
ph 203 785 4144  
fax 203 785 7232  
nancy.berliner@yale.edu

**Treasurer**

Andrew I Schafer, M D  
Department of Medicine  
Baylor College of Medicine  
6550 Fannin, SM 1423  
Houston, TX 77030  
ph 713 793 8300  
fax 713 793 8333  
aschafer@bcm.tmc.edu

**Councillors**

Karl G Blume, MD  
Hal E Broxmeyer, Ph D  
George R Buchanan, M D  
Janice L Gabrilove, M D  
James N George, M D  
Armand Keating, M D  
Kanti R Rai, M D  
J Evan Sadler, M D, Ph D

**Editor-in-Chief**

Kenneth Kaushansky, M D  
Division of Hematology  
University of Washington  
Box 357710, HSB K136  
Seattle, WA 98195-7710  
ph 206 685 7868  
fax 206 543 3560  
kkaushan@u.washington.edu

**Executive Director**

Martha L Liggett, Esq  
American Society of Hematology  
1900 M Street, NW, Suite 200  
Washington, DC 20036  
ph 202 776 0544  
fax 202 776 0545  
mliggett@hematology.org

October 11, 2002

American Medical Association  
Dept of CPT Editorial Research and Development  
515 North State Street  
Chicago, IL 60610

Dear Sir/Madam:

As recommended by the AMA RUC at their September 2002 meeting, the American Society of Hematology (ASH) would like to have the phrase "with physician evaluation" added to the definition of CPT 36516 for 2004 (the code is new for 2003). This would change the descriptor to read:

**▲ 36516 *therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion; with physician evaluation.***

This change is needed to assure that this code is billed only when the physician is present and periodically monitoring the patient during the procedure. The terminology is similar to that already existing for CPT 90935, hemodialysis procedure.

In addition, nine new bone marrow/stem cell processing codes were reviewed by the RUC (CPT codes 38207-38215) and the recommendation made that two of these be revised for 2004 (these are new codes for 2003). Specifically, CPT 38208 and CPT 38209 should change as follows:

**▲ 38208 thawing of previously frozen harvest, with washing ~~thawing of previously frozen harvest~~**

**▲ 38209 thawing of previously frozen harvest, without washing ~~washing of harvest~~**

The rationale for this revision is that bone marrow/stem cell washing is always done with bone marrow/stem cell thawing. However, all harvests that are thawed are not necessarily washed.

Finally, the AMA RUC recommended we petition CPT to add a note to these nine bone marrow/stem cell processing codes (CPT codes 38207-38215) indicating that physicians may not report flow cytometry (CPT codes 88180, 88182, and 88199) separately.

We understand that we do not need to submit a formal CPT application for these changes. If our understanding is not correct, please advise us as soon as possible.

If you have any questions or need additional information at this time, please feel free to contact Mo Mayrides, ASH Director of Policy and Practice, at (202) 292-6005 or at [mmayrides@hematology.org](mailto:mmayrides@hematology.org).

Sincerely,

Samuel M. Silver, MD, PhD  
Chair, ASH Committee on Practice

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION

---

CPT Code: 36511 Tracking Number: U1 Global Period: 000 ~~Recommended RVW: 2.1~~  
RUC Rec. RVW: 1.74

CPT Descriptor: Therapeutic apheresis; for white blood cells

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** The typical patient is a 40 year old female with acute leukemia who is found to have a leukemic blast count of  $\geq 50,000/\mu\text{l}$  or a total white blood cell count  $\geq 100,000/\mu\text{l}$ . At such very high white blood cell or leukemic blast counts there is an unacceptably high risk of cerebral or pulmonary leukostasis, a potentially fatal condition that results from obstruction of small arteries or arterioles by adherent white blood cells. Patients typically suffer strokes or respiratory failure.

Emergent lowering of the circulating white blood cell mass, by leukapheresis, is the only viable short-term management option. The patient is hospitalized for the apheresis procedure (any services directly related to the hospital admission should be billed separately and not included in your physician work assessment of the apheresis procedure). The apheresis physician assesses the appropriateness of the procedure and calculates the parameters of apheresis prior to the procedure. The machine's tubing system is connected to the patient's venous system through a large-bore, dual-lumen dialysis-type central venous catheter. While an apheresis nurse is operating the machine, the physician continually monitors the patient and assesses the patient at the end of the procedure.

**Description of Pre-Service Work:** [to be performed before every apheresis treatment, including the initial treatment]: The apheresis physician evaluates the general clinical status of the patient (including current medications), ascertaining whether he/she remains sufficiently stable to undergo the therapeutic extracorporeal procedure. In addition, the physician reviews the patient's hematological status to confirm that the treatments are having the desired effect on the hyperleukocytosis and whether the patient is clinically improving as expected. This assessment may include reviewing evaluations by other attending physicians including hematologists, nephrologists and intensivists involved in the patient's management. Current diagnostic laboratory studies are reviewed, including complete blood count and differential count, renal and liver function studies, total protein and albumin and other relevant serum chemistry studies. Urine output and the accumulation of edema fluid are assessed. The physician discusses the state of the patient's venous access with, and confirms the initial assessment of, the apheresis nurse. Finally, after determining that the parameters of the treatment (whole blood processing volume, anticoagulant-to-whole blood flow ratio, target extent of leukoreduction, etc.) as reflected in the orders are still appropriate, the physician authorizes that the treatment should proceed.

Pre-service work unique to the first treatment, in addition to all of the above, may include reviewing the patient's chest x-ray to determine proper placement of the venous access device (this is ultimately the responsibility of the apheresis physician), obtaining and reviewing the history and diagnostic studies; an examination of previous study reports; communicating with other professionals prior to the actual performance of the evaluation and procedure; and explaining the procedure to the patient or healthcare proxy and obtaining informed consent.

**Description of Intra-Service Work:** During the procedure, the apheresis physician is responsible for the wellbeing of the patient on the machine. The physician periodically assesses the clinical status of the patient, paying particular attention to the vital signs flow sheet, the patient's color, urine output, mental status (if patient is awake), and other relevant parameters. The physician monitors the decline in white cell count to determine whether the goals of the procedure are being met by the current treatment parameters as ordered, and ascertains that other formed elements of the blood are not being inappropriately altered as a result of the procedure. Variations in clinical status or vital signs are repeatedly evaluated to determine whether to continue the procedure to its intended extent of whole blood processing. Given the inherent level of acuity of patients undergoing this procedure, the apheresis physician is the first responder in case of adverse clinical events or emergencies that arise during the procedure.

**Description of Post-Service Work:** At the conclusion of the procedure the apheresis physician reviews final hematological parameters and assesses the extent to which goals for the procedure were met. The physician, in collaboration with the apheresis nurse ascertains that venous access has been properly de-accessed and that no new problems (hemorrhage, trauma, infection, etc.) have occurred as a result of the procedure. The physician prepares a final written report about the procedure for the medical record, and writes post-procedure orders should they be necessary and not already included in the apheresis orders that have already been ordered for the treatment series (this may relate to an unanticipated chest x-ray to assess caval erosion or catheter "pinch-off," for example, or a culture of a catheter exit site). The physician communicates in writing, in person and by telephone with other healthcare personnel regarding the patient's treatment and may discuss the progress of the series of treatments with the patient's family. The physician assesses the clinical condition of the patient and ascertains that no adverse effects have resulted from the procedure.

---

**SURVEY DATA:**

Presenter(s): Robert Weinstein, MD & Sam Silver, MD

Specialty(s): American Society of Hematology & Renal Physicians Association

Sample Size: 89 Response Rate: (%): 21% Median RVW: 2.05

Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Surveys were sent to providers who have experience with the surveyed procedures.

25th Percentile RVW: 1.91 75th Percentile RVW: 2.57 Low: 1.74 High: 14.6

**Median Pre-Service Time: 40 Median Intra-Service Time: 20**

25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 105 Low: 5 High: 240

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code &amp; # of Visits)</u>
<b>Immediate Post Service Time:</b>	<u>15</u>	
Critical Care:	<u>0</u>	_____
Other Hospital Visits:	<u>0</u>	_____
Discharge Day Mgmt.:	<u>0</u>	_____
Office Visits:	<u>0</u>	_____

---

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
36520	Therapeutic apheresis; plasma or cell exchange	000	1.74

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

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

**TIME ESTIMATES (Median)**

	<b>New/Revis. CPT Code: <u>3651X1</u></b>	<b>Key Reference CPT Code: <u>36520</u></b>
Median Pre-Time	40	20
Median Intra-Time	20	60
Median Immediate Post-service Time	15	20
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.84	3.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.95	4.11
Urgency of medical decision making	4.68	4.17

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.26	3.94
Physical effort required	2.95	3.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.47	4.11
Outcome depends on the skill and judgement of physician	4.26	4.39
Estimated risk of malpractice suit with poor outcome	3.21	3.33

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference  
Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.94	3.72
Intra-Service intensity/complexity	4.26	3.95
Post-Service intensity/complexity	3.26	3.32

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

The survey data for the 6 codes was reviewed by several physicians from the American Society of Hematology, the American Society for Apheresis and the Hemapheresis Committee of the American Association of Blood Banks. The Renal Physicians Association has also reviewed this data. The median work value recommended for each of the 6 codes varied very slightly, generally less than 0.1 of an RVU. We think the variation was due largely to minor differences in the mix of survey respondents for the 6 codes. We are recommending the work value of 2.1 for all 6 codes which is less than the median survey value for 4 codes (including the highest volume code) and very slightly higher than the median for 2 of the codes (2.05 for 3652X1 and 1.94 for Code 3551X3).

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

---

**FREQUENCY INFORMATION**

How was this service previously reported? 36520 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Hematology Commonly  Sometimes Rarely

Specialty Nephrology Commonly  Sometimes Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Hematology Frequency                     

Specialty Nephrology Frequency                     

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

Specialty Hematology Frequency 1297 (Based on CPT Code 36520 for 2001)

Specialty Nephrology Frequency 5913 (Based on CPT Code 36520 for 2001)

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

---

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION

---

CPT Code: 36512 Tracking Number: U2 Global Period: 000 ~~Recommended RVW: 2.1~~  
RUC Rec. RVW: 1.74

CPT Descriptor: Therapeutic apheresis; for red blood cells

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** The typical patient is a 21-year-old man with sickle cell anemia who has suffered a cerebral infarction and is at very high risk of recurrent stroke. The only effective method for preventing a recurrence is to have his blood chronically replaced with non-sickling blood. Simple red blood cell transfusion therapy is not acceptable or appropriate because it would result in transfusional iron overload, a condition that results in heart failure, liver failure and death. Red blood cell exchange by apheresis does not result in iron overload. The apheresis physician assesses the patient prior to initiating the procedure and determines the treatment parameters necessary to achieve the targeted substitution of hemoglobin A blood for sickle hemoglobin blood. The patient is connected to the apheresis machine using a large-bore, dual-lumen dialysis catheter. Typically, an apheresis nurse operates the machine with the physician monitoring the patient at bedside. The patient is assessed at the end of the apheresis procedure. A final assessment is performed at the termination of the procedure.

**Description of Pre-Service Work:** [to be performed before every apheresis treatment, including the initial treatment]: The apheresis physician evaluates the general clinical status of the patient (including current medications), ascertaining whether he/she is sufficiently well to undergo the therapeutic extracorporeal procedure. In addition, the physician reviews the patient's hematological status to confirm that the treatments are having the desired effect on the ratio of hemoglobins (HgbA:HgbS, for example). An interval history and brief physical assessment are performed. This assessment may include reviewing evaluations by other attending physicians including hematologists, nephrologists and neurologists involved in the patient's management. The physician discusses the state of the patient's venous access with, and confirms the initial assessment of, the apheresis nurse. Current diagnostic laboratory studies are reviewed, including complete blood count and differential count, renal and liver function studies, total protein and albumin and other relevant serum chemistry studies. The physician determines that the patient's blood group and Rh type have been properly determined and that compatible packed red blood cells have been ordered for the procedure. Finally, after determining that the parameters of the treatment (whole blood processing volume, anticoagulant-to-whole blood flow ratio, units of red packed red cells to be used, target hemoglobin ratio, final desired hemoglobin and hematocrit, etc.) as reflected in the orders are still appropriate, the physician authorizes that the treatment should proceed.

Pre-service work unique to the first treatment, in addition to all of the above, may include reviewing the patient's chest x-ray to determine proper placement of the venous access device (this is ultimately the responsibility of the apheresis physician), obtaining and reviewing the history and diagnostic studies; an examination of previous study reports; communicating with other professionals prior to the actual performance of the evaluation and procedure; and explaining the procedure to the patient or healthcare proxy and obtaining informed consent.

**Description of Intra-Service Work:** During the procedure, the apheresis physician is responsible for the wellbeing of the patient on the machine. The physician periodically assesses the clinical status of the patient, paying particular attention to the vital signs flow sheet, the patient's color, urine output, mental status (if patient is awake), and other relevant parameters. The physician monitors the patient's hemoglobin and hematocrit, the presence or absence of hemolysis (as detected in the extracorporeal circuit or in the color of the patient's urine), and carefully monitors the patient for intolerance to the procedure or development of signs and symptoms of a transfusion reaction. In addition, the physician ascertains that other formed elements of the blood are not being inappropriately altered as a result of the procedure. Variations in clinical status or vital signs are repeatedly evaluated to determine whether to continue the procedure to its intended extent of whole blood processing. Given the inherent potential level of acuity of patients undergoing this procedure, the apheresis physician is the first responder in case of adverse clinical events or emergencies that arise during the procedure.

**Description of Post-Service Work:** At the conclusion of the procedure the apheresis physician reviews final hematological parameters and assesses the extent to which goals for the procedure were met. This may include ordering post-procedure laboratory tests to be interpreted before the following procedure (vida supra). The physician, in collaboration with the apheresis nurse ascertains that venous access has been properly de-accessed and that no new problems (hemorrhage, trauma, infection, etc.) have occurred as a result of the procedure. The physician prepares a final written report about the procedure for the medical record, and writes post-procedure orders should they be necessary and not already included in the apheresis orders that have already been ordered for the treatment series (this may relate to an unanticipated chest x-ray to assess caval erosion or catheter "pinch-off," for example, or a culture of a catheter exit site). The physician communicates in writing, in person and by telephone with other healthcare personnel regarding the patient's treatment and may discuss the progress of the series of treatments with the patient's family. The physician assesses the clinical condition of the patient and ascertains that no adverse effects have resulted from the procedure.



**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
36520	Therapeutic apheresis; plasma or cell exchange	000	1.74

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

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

<u>TIME ESTIMATES (Median)</u>	<u>New/Revis. CPT Code: 3651X2</u>	<u>Key Reference CPT Code: 36520</u>
Median Pre-Time	40	20
Median Intra-Time	20	60
Median Immediate Post-service Time	15	20
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.59	3.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.82	3.94
Urgency of medical decision making	4.12	3.94

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.12	3.63
Physical effort required	3.00	2.81

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.29	3.94
Outcome depends on the skill and judgement of physician	4.06	4.06
Estimated risk of malpractice suit with poor outcome	3.65	3.44

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference  
Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	4.06	3.87
Intra-Service intensity/complexity	3.94	3.88
Post-Service intensity/complexity	3.41	3.25

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

The survey data for the 6 codes was reviewed by several physicians from the American Society of Hematology, the American Society for Apheresis and the Hemapheresis Committee of the American Association of Blood Banks. The Renal Physicians Association has also reviewed this data. The median work value recommended for each of the 6 codes varied very slightly, generally less than 0.1 of an RVU. We think the variation was due largely to minor differences in the mix of survey respondents for the 6 codes. We are recommending the work value of 2.1 for all 6 codes which is less than the median survey value for 4 codes (including the highest volume code) and very slightly higher than the median for 2 of the codes (2.05 for 3652X1 and 1.94 for Code 3551X3).

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

---

## FREQUENCY INFORMATION

How was this service previously reported? 36520 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Hematology \_\_\_\_\_ Commonly  Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_

Specialty Nephrology \_\_\_\_\_ Commonly  Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Hematology \_\_\_\_\_ Frequency \_\_\_\_\_

Specialty Nephrology \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty Hematology \_\_\_\_\_ Frequency 1297 (Based on CPT Code 36520 for 2001)

Specialty Nephrology \_\_\_\_\_ Frequency 5913 (Based on CPT Code 36520 for 2001)

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

---

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

---

CPT Code: 36513 Tracking Number: U3 Global Period: 000 ~~Recommended RVW: 2.1~~  
RUC Rec. RVW: **1.74**

CPT Descriptor: Therapeutic apheresis; for platelets

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** The typical patient is a 65-year-old male with a myeloproliferative disorder (essential thrombocythemia, chronic myelogenous leukemia or polycythemia vera) whose platelet count is unusually high ( $\geq 1,000,000/\mu\text{l}$ ). Because of the degree of thrombocytosis, there is a high risk of coronary or cerebral infarction. Therapeutic apheresis is performed emergently because of altered mental status resulting from the thrombocytosis. The apheresis physician assesses the patient and determines the appropriateness of therapeutic apheresis. The physician calculates the exchange parameters and writes orders for the procedure. The physician is in attendance throughout the procedure. The patient is assessed at the end of the apheresis procedure.

**Description of Pre-Service Work:** [to be performed before every apheresis treatment, including the initial treatment]: The apheresis physician evaluates the general clinical status of the patient (including current medications), ascertaining whether he/she remains sufficiently stable to undergo the therapeutic extracorporeal procedure. In addition, the physician reviews the patient's hematological status to confirm that the treatments are having the desired effect on the hyperthrombocytosis and whether the patient is clinically improving as expected. This assessment may include reviewing evaluations by other attending physicians including hematologists, nephrologists and intensivists involved in the patient's management. Current diagnostic laboratory studies are reviewed, including complete blood count and differential count, renal and liver function studies, total protein and albumin and other relevant serum chemistry studies. Urine output and the accumulation of edema fluid are assessed. The physician discusses the state of the patient's venous access with, and confirms the initial assessment of, the apheresis nurse. Finally, after determining that the parameters of the treatment (whole blood processing volume, anticoagulant-to-whole blood flow ratio, target extent of thromboreduction, etc.) as reflected in the orders are still appropriate, the physician authorizes that the treatment should proceed.

Pre-service work unique to the first treatment, in addition to all of the above, may include reviewing the patient's chest x-ray to determine proper placement of the venous access device (this is ultimately the responsibility of the apheresis physician), obtaining and reviewing the history and diagnostic studies; an examination of previous study reports; communicating with other professionals prior to the actual performance of the evaluation and procedure; and explaining the procedure to the patient or healthcare proxy and obtaining informed consent.

**Description of Intra-Service Work:** During the procedure, the apheresis physician is responsible for the wellbeing of the patient on the machine. The physician periodically assesses the clinical status of the patient, paying particular attention to the vital signs flow sheet, the patient's color, urine output, mental status (if patient is awake), and other relevant parameters. The physician monitors the decline in platelet count to determine whether the goals of the procedure are being met by the current treatment parameters as ordered, and ascertains that other formed elements of the blood are not being inappropriately altered as a result of the procedure. Variations in clinical status or vital signs are repeatedly evaluated to determine whether to continue the procedure to its intended extent of whole blood processing. Given the inherent level of acuity of patients undergoing this procedure, the apheresis physician is the first responder in case of adverse clinical events or emergencies that arise during the procedure.

**Description of Post-Service Work:** At the conclusion of the procedure the apheresis physician reviews final hematological parameters and assesses the extent to which goals for the procedure were met. The physician, in collaboration with the apheresis nurse ascertains that venous access has been properly de-accessed and that no new problems (hemorrhage, trauma, infection, etc.) have occurred as a result of the procedure. The physician prepares a final written report about the procedure for the medical record, and writes post-procedure orders should they be necessary and not already included in the apheresis orders that have already been ordered for the treatment series (this may relate to an unanticipated chest x-ray to assess caval erosion or catheter "pinch-off," for example, or a culture of a catheter exit site). The physician communicates in writing, in person and by telephone with other healthcare personnel regarding the patient's treatment and may discuss the progress of the series of treatments with the patient's family. The physician assesses the clinical condition of the patient and ascertains that no adverse effects have resulted from the procedure.

---

**SURVEY DATA:**Presenter(s): Robert Weinstein, MD & Sam Silver, MDSpecialty(s): American Society of Hematology & Renal Physicians AssociationSample Size: 89 Response Rate: (%): 19% Median RVW: 1.94Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Surveys were sent to providers who have experience with the surveyed procedures.25th Percentile RVW: 1.8 75th Percentile RVW: 2.25 Low: 1.74 High: 14.6Median Pre-Service Time: 40 Median Intra-Service Time: 2025th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 105 Low: 5 High: 180

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code &amp; # of Visits)</u>
<b>Immediate Post Service Time:</b>	<u>15</u>	
Critical Care:	<u>0</u>	_____
Other Hospital Visits:	<u>0</u>	_____
Discharge Day Mgmt.:	<u>0</u>	_____
Office Visits:	<u>0</u>	_____

---

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
36520	Therapeutic apheresis; plasma or cell exchange	000	1.74

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

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

**TIME ESTIMATES (Median)**

	<u>New/Revis. CPT Code: 3651X3</u>	<u>Key Reference CPT Code: 36520</u>
Median Pre-Time	40	20
Median Intra-Time	20	60
Median Immediate Post-service Time	15	20
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.82	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.88	4.12
Urgency of medical decision making	4.71	4.18

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.35	3.94
Physical effort required	3.06	3.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.47	4.12
Outcome depends on the skill and judgement of physician	4.18	4.24
Estimated risk of malpractice suit with poor outcome	3.59	3.47

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.94	3.69
Intra-Service intensity/complexity	4.12	4.00
Post-Service intensity/complexity	3.59	3.35

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

The survey data for the 6 codes was reviewed by several physicians from the American Society of Hematology, the American Society for Apheresis and the Hemapheresis Committee of the American Association of Blood Banks. The Renal Physicians Association has also reviewed this data. The median work value recommended for each of the 6 codes varied very slightly, generally less than 0.1 of an RVU. We think the variation was due largely to minor differences in the mix of survey respondents for the 6 codes. We are recommending the work value of 2.1 for all 6 codes which is less than the median survey value for 4 codes (including the highest volume code) and very slightly higher than the median for 2 of the codes (2.05 for 3652X1 and 1.94 for Code 3551X3).

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

---

**FREQUENCY INFORMATION**

How was this service previously reported? 36520 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Hematology Commonly  Sometimes Rarely

Specialty Nephrology Commonly  Sometimes Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Hematology Frequency                     

Specialty Nephrology Frequency                     

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

Specialty Hematology Frequency 1297 (Based on CPT Code 36520 for 2001)

Specialty Nephrology Frequency 5913 (Based on CPT Code 36520 for 2001)

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

---

## AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS

### SUMMARY OF RECOMMENDATION

CPT Code: 36514 Tracking Number: U4 Global Period: 000 ~~Recommended RVW: 2.1~~

RUC Rec. RVW: 1.74

CPT Descriptor: Therapeutic apheresis; for plasma pheresis

#### CLINICAL DESCRIPTION OF SERVICE:

**Vignette Used in Survey:** The typical patient is a 25-year-old male with thrombotic thrombocytopenic purpura. The universally accepted first line therapy for this life-threatening condition is therapeutic plasma exchange. The apheresis physician assesses the patient prior to the procedure, paying particular attention to clinical parameters that determine the patient's ability to tolerate exposure to unusually large volumes of allogeneic plasma. The apheresis physician writes orders for the procedure, which often must be performed on a daily basis, determines the appropriate biological replacement fluid, and manages blood product support. These patients are typically treated using a dual-lumen, large bore dialysis-type catheter. The apheresis physician manages the catheter and monitors the patient for catheter-related complications. The patient's blood is drawn into a centrifuge in the machine and the plasma is separated from the cellular components. The plasma is diverted to a collection bag and the cells are returned to the patient with a biological replacement fluid such as allogeneic plasma or human serum albumin as determined by the apheresis physician. The apheresis physician closely monitors the patient for allergic reactions to the biological replacement fluids and transfusion reactions that may occur when plasma is the replacement fluid. The patient is assessed at the end of the apheresis procedure.

#### **Description of Pre-Service Work:** [to be performed before every apheresis treatment, including the initial treatment]:

The apheresis physician evaluates the general clinical status of the patient (including current medications), ascertaining whether he/she remains sufficiently stable to undergo the therapeutic extracorporeal procedure and is clinically responding to treatment as expected. In addition, the physician reviews disease-specific parameters (when relevant) to confirm that the treatments are having the desired effect. In the case of TTP, for example, particular attention is paid to platelet count, serum LDH and the morphology of the red blood cells on the peripheral blood film. This assessment also includes reviewing evaluations by other attending physicians including hematologists, nephrologists, neurologists and intensivists involved in the patient's management. Current diagnostic laboratory studies are reviewed, including complete blood count and differential count, renal and liver function studies, total protein and albumin and other relevant serum chemistry studies. Urine output and the accumulation of edema fluid are assessed. The physician discusses the state of the patient's venous access with, and confirms the initial assessment of, the apheresis nurse. The physician confirms that the patient's blood group has been correctly recorded and that the fresh frozen (or cryo-poor) plasma exchange fluid is compatible with the patient). When necessary the apheresis orders supplemental treatments to be applied during the procedure (a diphenhydramine drip, for example, for a patient who tolerates plasma infusions poorly). Finally, after determining that the parameters of the treatment (whole blood processing volume, anticoagulant-to-whole blood flow ratio, plasma volumes to be exchanged, etc.) as reflected in the orders are still appropriate, the physician authorizes that the treatment should proceed.

Pre-service work unique to the first treatment, in addition to all of the above, may include reviewing the patient's chest x-ray to determine proper placement of the venous access device (this is ultimately the responsibility of the apheresis physician), obtaining and reviewing the history and diagnostic studies; an examination of previous study reports; communicating with other professionals prior to the actual performance of the evaluation and procedure; and explaining the procedure to the patient or healthcare proxy and obtaining informed consent.

**Description of Intra-Service Work:** During the procedure, the apheresis physician is responsible for the wellbeing of the patient on the machine. The physician periodically assesses the clinical status of the patient, paying particular attention to the vital signs flow sheet, the patient's color, urine output, mental status (if patient is awake), and other relevant parameters. The physician monitors the patient for the development of reactions to the plasma exchange fluid and orders supplemental treatments as necessary. Variations in clinical status or vital signs are repeatedly evaluated to determine whether to continue the procedure to its intended extent of whole blood processing. Given the inherent level of acuity of patients undergoing this procedure, the apheresis physician is the first responder in case of adverse clinical events or emergencies that arise during the procedure.

**Description of Post-Service Work:** At the conclusion of the procedure the apheresis physician reviews final hematological parameters and assesses the extent to which goals for the procedure were met. The physician, in collaboration with the apheresis nurse ascertains that venous access has been properly de-accessed and that no new problems (hemorrhage, trauma, infection, etc.) have occurred as a result of the procedure. The physician prepares a final written report about the procedure for the medical record, and writes post-procedure orders should they be necessary and not already included in the apheresis orders that have already been ordered for the treatment series (this may relate to an unanticipated chest x-ray to assess caval erosion or catheter "pinch-off," for example, or a culture of a catheter exit site). The physician communicates in writing, in person and by telephone with other healthcare personnel regarding the patient's treatment and may discuss the progress of the series of treatments with the patient's family. The physician assesses the clinical condition of the patient and ascertains that no adverse effects have resulted from the procedure.

---

**SURVEY DATA:**Presenter(s): Robert Weinstein, MD & Sam Silver, MDSpecialty(s): American Society of Hematology & Renal Physicians AssociationSample Size: 89 Response Rate: (%): 26% Median RVW: 2.16Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Surveys were sent to providers who have experience with the surveyed procedures.25th Percentile RVW: 1.74 75th Percentile RVW: 2.9 Low: 1.25 High: 14.6Median Pre-Service Time: ~~40~~ 30 Median Intra-Service Time: 20 ~~25~~25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 70 Low: 5 High: 180

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code &amp; # of Visits)</u>
<b>Immediate Post Service Time:</b>	<u>15</u>	
Critical Care:	<u>0</u>	_____
Other Hospital Visits:	<u>0</u>	_____
Discharge Day Mgmt.:	<u>0</u>	_____
Office Visits:	<u>0</u>	_____

---

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
36520	Therapeutic apheresis; plasma or cell exchange	000	1.74

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

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

**TIME ESTIMATES (Median)**

	<u>New/Revis. CPT Code: 3651X4</u>	<u>Key Reference CPT Code: 36520</u>
Median Pre-Time	40	20
Median Intra-Time	20	60
Median Immediate Post-service Time	15	20
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.17	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.09	4.04
Urgency of medical decision making	4.52	4.04

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.17	3.91
Physical effort required	3.39	3.22

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.43	4.04
Outcome depends on the skill and judgement of physician	4.43	4.23
Estimated risk of malpractice suit with poor outcome	3.87	3.52

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference**  
**Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.73	3.59
Intra-Service intensity/complexity	4.09	3.91
Post-Service intensity/complexity	3.57	3.35

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

The survey data for the 6 codes was reviewed by several physicians from the American Society of Hematology, the American Society for Apheresis and the Hemapheresis Committee of the American Association of Blood Banks. The Renal Physicians Association has also reviewed this data. The median work value recommended for each of the 6 codes varied very slightly, generally less than 0.1 of an RVU. We think the variation was due largely to minor differences in the mix of survey respondents for the 6 codes. We are recommending the work value of 2.1 for all 6 codes which is less than the median survey value for 4 codes (including the highest volume code) and very slightly higher than the median for 2 of the codes (2.05 for 3652X1 and 1.94 for Code 3551X3).

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

---

**FREQUENCY INFORMATION**

How was this service previously reported? 36520 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Hematology Commonly  Sometimes Rarely

Specialty Nephrology Commonly  Sometimes Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Hematology Frequency                     

Specialty Nephrology Frequency                     

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

Specialty Hematology Frequency 1297 (Based on CPT Code 36520 for 2001)

Specialty Nephrology Frequency 5913 (Based on CPT Code 36520 for 2001)

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

---

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

---

CPT Code: 36515 Tracking Number: U5 Global Period: 000 ~~Recommended RVW: 2.1~~

**RUC Rec. RVW: 1.74**

CPT Descriptor: Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** The typical patient has moderate to severe immune thrombocytopenia, with HIV infection, and is unresponsive to medical therapy. The patient is bleeding and the procedure is performed under emergency conditions. It is necessary to increase the platelet count. The apheresis procedure is indicated for removal of high-titer, high avidity IgG anti-platelet antibodies from the patient's plasma without removing other plasma proteins such as clotting factors and fibrinogen. The apheresis machine is used to separate the patient's plasma from the cellular components of whole blood so that the plasma can be adsorbed on a special affinity column, which removes IgG and pathogenic immune complexes but allows the rest of the plasma constituents to pass through unadsorbed. The resulting immunomodulation reduces the anti-platelet antibody titer and restores the regulatory activity of the idiotypic network, thus relieving the immune thrombocytopenia. The patient is closely monitored by the physician for allergic reactions or other complications requiring physician intervention.

**Description of Pre-Service Work:** [to be performed before every apheresis treatment, including the initial treatment]: The apheresis physician evaluates the general clinical status of the patient (including current medications), ascertaining whether he/she remains sufficiently stable to undergo the therapeutic extracorporeal procedure and is clinically responding to treatment as expected. In addition, the physician reviews disease-specific parameters (e.g. the platelet count in the case of ITP) to confirm that the treatments are having the desired effect. This assessment also includes reviewing evaluations by other attending physicians including hematologists, nephrologists, neurologists and intensivists involved in the patient's management, and determining whether the patient has been started on medications, since the previous treatment, that would increase the risk of adverse effects of treatment. Current diagnostic laboratory studies are reviewed, including complete blood count and differential count, renal and liver function studies, total protein and albumin and other relevant serum chemistry studies. Urine output and the accumulation of edema fluid are assessed. The physician discusses the state of the patient's venous access with, and confirms the initial assessment of, the apheresis nurse. Finally, after determining that the parameters of the treatment (whole blood processing volume, anticoagulant-to-whole blood flow ratio, plasma volume to be adsorbed, supplements to be added to the crystalloid fluids to be returned to the patient, etc.) as reflected in the orders are still appropriate, the physician authorizes that the treatment should proceed.

Pre-service work unique to the first treatment, in addition to all of the above, may include reviewing the patient's chest x-ray to determine proper placement of the venous access device (this is ultimately the responsibility of the apheresis physician), obtaining and reviewing the history and diagnostic studies; an examination of previous study reports; communicating with other professionals prior to the actual performance of the evaluation and procedure; and explaining the procedure to the patient or healthcare proxy and obtaining informed consent.

**Description of Intra-Service Work:** During the procedure, the apheresis physician is responsible for the wellbeing of the patient on the machine. The physician periodically assesses the clinical status of the patient, paying particular attention to the vital signs flow sheet, the patient's color, urine output, mental status (if patient is awake), and other relevant parameters. The physician monitors the patient for the development of reactions to the infusion of adsorbed autologous plasma and orders supplemental treatments as necessary. Variations in clinical status or vital signs are repeatedly evaluated to determine whether to continue the procedure to its intended extent of whole blood processing. Given the inherent level of acuity of patients undergoing this procedure, the apheresis physician is the first responder in case of adverse clinical events or emergencies that arise during the procedure.

**Description of Post-Service Work:** At the conclusion of the procedure the apheresis physician reviews final hematological parameters and assesses the extent to which goals for the procedure were met. The physician, in collaboration with the apheresis nurse ascertains that venous access has been properly de-accessed and that no new problems (hemorrhage, trauma, infection, etc.) have occurred as a result of the procedure. The physician prepares a final written report about the procedure for the medical record, and writes post-procedure orders should they be necessary and not already included in the apheresis orders that have already been written for the treatment series (this may relate to an unanticipated chest x-ray to assess caval erosion or catheter "pinch-off," for example, or a culture of a catheter exit site). The physician communicates in writing, in person and by telephone with other healthcare personnel regarding the patient's treatment and may discuss the progress of the series of treatments with the patient's family. The physician assesses the clinical condition of the patient and ascertains that no adverse effects have resulted from the procedure.

---

**SURVEY DATA:**Presenter(s): Robert Weinstein, MD & Sam Silver, MDSpecialty(s): American Society of Hematology & Renal Physicians AssociationSample Size: 89 Response Rate: (%): 17% Median RVW: 2.11Type of Sample (Circle One): random, panel, convenience. Explanation of sample size: Surveys were sent to providers who have experience with the surveyed procedures.25th Percentile RVW: 1.92 75th Percentile RVW: 3.65 Low: 1.74 High: 14.6Median Pre-Service Time: **40** ~~30~~ Median Intra-Service Time: **20** ~~30~~25th Percentile Intra-Svc Time: 15 75th Percentile Intra-Svc Time: 75 Low: 10 High: 180

Median Post-Service Time:

	<u>Total Time</u>	<u>Level of Service by CPT Code (List CPT Code &amp; # of Visits)</u>
<b>Immediate Post Service Time:</b>	<u>15</u>	
Critical Care:	<u>0</u>	
Other Hospital Visits:	<u>0</u>	
Discharge Day Mgmt.:	<u>0</u>	
Office Visits:	<u>0</u>	

---

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
36520	Therapeutic apheresis; plasma or cell exchange	000	1.74

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

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

**TIME ESTIMATES (Median)**

	<u>New/Revis. CPT Code: 3651X5</u>	<u>Key Reference CPT Code: 36520</u>
Median Pre-Time	40	20
Median Intra-Time	20	60
Median Immediate Post-service Time	15	20
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.13	4.20
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.20	4.13
Urgency of medical decision making	4.20	4.27

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.47	4.20
Physical effort required	3.27	3.07

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.53	4.20
Outcome depends on the skill and judgement of physician	4.33	4.40
Estimated risk of malpractice suit with poor outcome	3.73	3.60

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference  
Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	4.00	3.85
Intra-Service intensity/complexity	4.40	4.14
Post-Service intensity/complexity	3.60	3.43

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

The survey data for the 6 codes was reviewed by several physicians from the American Society of Hematology, the American Society for Apheresis and the Hemapheresis Committee of the American Association of Blood Banks. The Renal Physicians Association has also reviewed this data. The median work value recommended for each of the 6 codes varied very slightly, generally less than 0.1 of an RVU. We think the variation was due largely to minor differences in the mix of survey respondents for the 6 codes. We are recommending the work value of 2.1 for all 6 codes which is less than the median survey value for 4 codes (including the highest volume code) and very slightly higher than the median for 2 of the codes (2.05 for 3652X1 and 1.94 for Code 3551X3).

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

---

**FREQUENCY INFORMATION**

How was this service previously reported? 36520 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Hematology Commonly Sometimes X Rarely

Specialty Nephrology Commonly Sometimes X Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Hematology Frequency                     

Specialty Nephrology Frequency                     

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

Specialty Hematology Frequency 1297 (Based on CPT Code 36520 for 2001)

Specialty Nephrology Frequency 5913 (Based on CPT Code 36520 for 2001)

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

---

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION

---

CPT Code: 36516 Tracking Number: U6 Global Period: 000 ~~Recommended RVW: 2.1~~  
RUC Rec. RVW: 1.22

CPT Descriptor: Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:** The typical patient is a homozygote or heterozygote with familial hypercholesterolemia whose serum lipids have not been satisfactorily controlled with maximum medical therapy. The patient has had a history of myocardial infarctions before age 40. Weekly or semi-monthly lipid apheresis is the only effective method for controlling symptomatic hyperlipidemias. The apheresis physician is responsible for assessing the appropriateness of this therapy for the individual patient, for writing appropriate orders and for managing the patient during treatments. A venous access device is required which the apheresis physician is responsible for managing. Plasma separation is performed and LDL cholesterol is selectively removed. Depending on the specific device used, the patient's treated plasma may require post-adsorption treatment prior to being reinfused into the patient. The patient is monitored throughout the procedure for allergic reactions and for thrombocytopenia. The patient is assessed at the end of the apheresis procedure.

**Description of Pre-Service Work:** [to be performed before every apheresis treatment, including the initial treatment]: The apheresis physician evaluates the general clinical status of the patient (including current medications), ascertaining whether he/she remains sufficiently stable to undergo the therapeutic extracorporeal procedure and is clinically responding to treatment as expected. Particular attention is paid to potential symptoms of unstable coronary disease which may have appeared in the interval since the last treatment. In addition, the physician reviews disease-specific parameters (e.g. the total cholesterol and/or triglyceride level) to confirm that the treatments are having the desired effect. This assessment also includes reviewing evaluations by other attending physicians including cardiologists, nephrologists, neurologists and the primary care physician involved in the patient's management, and determining whether the patient has been started on medications, since the previous treatment, that would increase the risk of adverse effects of treatment. Current diagnostic laboratory studies are reviewed, including complete blood count and differential count, renal and liver function studies, total protein and albumin and other relevant serum chemistry studies. Urine output and the accumulation of edema fluid are assessed. The physician discusses the state of the patient's venous access with, and confirms the initial assessment of, the apheresis nurse. Finally, after determining that the parameters of the treatment (whole blood processing volume, anticoagulant-to-whole blood flow ratio, plasma volume to be adsorbed, supplements to be added to the crystalloid fluids to be returned to the patient, etc.) as reflected in the orders are still appropriate, the physician authorizes that the treatment should proceed.

Pre-service work unique to the first treatment, in addition to all of the above, may include reviewing the patient's chest x-ray to determine proper placement of the venous access device (this is ultimately the responsibility of the apheresis physician), obtaining and reviewing the history and diagnostic studies; an examination of previous study reports; communicating with other professionals prior to the actual performance of the evaluation and procedure; and explaining the procedure to the patient or healthcare proxy and obtaining informed consent.

**Description of Intra-Service Work:** During the procedure, the apheresis physician is responsible for the wellbeing of the patient on the machine. The physician periodically assesses the clinical status of the patient, paying particular attention to the vital signs flow sheet, the patient's color, urine output, mental status (if patient is awake), and other relevant parameters. The physician monitors the patient for the development of reactions to the infusion of adsorbed autologous plasma or for complaints suggestive of active coronary disease and orders supplemental treatments as necessary. Variations in clinical status or vital signs are repeatedly evaluated to determine whether to continue the procedure to its intended extent of whole blood processing. Given the inherent level of acuity of patients undergoing this procedure, the apheresis physician is the first responder in case of adverse clinical events or emergencies that arise during the procedure.

**Description of Post-Service Work:** At the conclusion of the procedure the apheresis physician reviews final fluid parameters and assesses the extent to which goals for the procedure were met. The physician, in collaboration with the apheresis nurse ascertains that venous access has been properly de-accessed and that no new problems (hemorrhage, trauma, infection, etc.) have occurred as a result of the procedure. The physician prepares a final written report about the procedure for the medical record, and writes post-procedure orders should they be necessary and not already included in the apheresis orders that have already been written for the treatment series (this may relate to an unanticipated chest x-ray to assess caval erosion or catheter "pinch-off," for example, or a culture of a catheter exit site). The physician communicates in writing, in person and by telephone with other healthcare personnel regarding the patient's treatment and may discuss the progress of the series of treatments with the patient's family. The physician assesses the clinical condition of the patient and ascertains that no adverse effects have resulted from the procedure.



**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
90937	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription	000	2.11

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

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

**TIME ESTIMATES (Median)**

	<u>New/Revis. CPT Code:</u> <u>3651X6</u>	<u>Key Reference CPT Code:</u> <u>90937</u>
Median Pre-Time	25	*
		*pre/post = 8
Median Intra-Time	15	55
Median Immediate Post-service Time	10	*
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.56	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.75
Urgency of medical decision making	3.11	3.75

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.78	3.88
Physical effort required	2.89	2.63

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.56	3.75
Outcome depends on the skill and judgement of physician	3.78	4.25
Estimated risk of malpractice suit with poor outcome	3.22	3.13

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference  
Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.38	3.75
Intra-Service intensity/complexity	3.67	3.89
Post-Service intensity/complexity	3.33	3.33

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

The survey data for the 6 codes was reviewed by several physicians from the American Society of Hematology, the American Society for Apheresis and the Hemapheresis Committee of the American Association of Blood Banks. The Renal Physicians Association has also reviewed this data. The median work value recommended for each of the 6 codes varied very slightly, generally less than 0.1 of an RVU. We think the variation was due largely to minor differences in the mix of survey respondents for the 6 codes. We are recommending the work value of 2.1 for all 6 codes which is less than the median survey value for 4 codes (including the highest volume code) and very slightly higher than the median for 2 of the codes (2.05 for 3652X1 and 1.94 for Code 3551X3).

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

---

**FREQUENCY INFORMATION**

How was this service previously reported? 90937 (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty Hematology Commonly Sometimes X Rarely

Specialty Nephrology Commonly Sometimes X Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Hematology Frequency                     

Specialty Nephrology Frequency                     

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

Specialty Hematology Frequency 1297 (Based on CPT Code 36520 for 2001)

Specialty Nephrology Frequency 5913 (Based on CPT Code 36520 for 2001)

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

---

**RUC and RUC HCPAC REVIEW BOARD**  
**Recommendations**  
**For CPT 2004**

# American Medical Association

Physicians dedicated to the health of America



William L. Rich III, MD, FACS    515 North State Street    312 464-5604  
Chairman    Chicago, Illinois 60610    312 464-5849 Fax  
AMA/Specialty Society RVS  
Update Committee

October 7, 2004

Mark B. McClellan, MD, PhD  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, D.C. 20201

Dear Doctor McClellan:

The American Medical Association/Specialty Society RVS Update Committee (RUC) met on September 29-October 2, 2004 to consider recommendations related to drug administration services and other new/revised codes for *CPT 2005*. We understand that CMS is currently in the process of preparing the *Final Rule* on the 2005 Medicare Physician Payment Schedule. We urge CMS to consider these recommendations in the publication of this *Final Rule*, expected to be published in the *Federal Register* on November 1, 2004.

Attached are documents including work relative value recommendations, direct practice inputs, utilization crosswalks, and suggested PLI relative value crosswalks for the following issues:

- Drug Administration Services (90760 - 90775 and 96401 - 96523)
- Tissue Debridement of Genitalia for Gangrene (11004, 11005, 11006 and 11008)
- Endometrial Cryoablation Therapy (58356)
- Doppler Velocimetry, Umbilical and Middle Cerebral Arteries (76820 and 76821)
- Flow Cytometry (88184 - 88189)
- Immunohistochemistry/In Situ Hybridization (eg, FISH) Procedures (88360 - 88368)

The RUC understands that new coding structure for flow cytometry (CPT codes 88184-88189) will result in an overall savings. We request that CMS consider these savings, much like you often consider budget increases for CPT codes which represent unbundled services.

Mark B. McClellan, MD, PhD  
October 7, 2004  
Page Two

These savings should be considered to offset other increases resulting from coding changes and refinements to one of the components of the RBRVS. If the savings for this new coding structure for flow cytometry are greater than the increases for other coding changes or relative value refinements, a positive adjustment should be made to the conversion factor.

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

Sincerely,

A handwritten signature in black ink that reads "William L. Rich, III, MD, FACS". The signature is written in a cursive style.

William L. Rich, III, MD, FACS

cc: RUC participants  
Attachments

May 29, 2003

Terry Kay  
Center for Health Plans and Providers  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard, C4-01-15  
Baltimore, Maryland 21244

Dear Mr. Kay:

It is with pleasure that we submit to the Centers for Medicare and Medicaid Services (CMS), on behalf of the RUC Health Care Professionals Advisory Committee (HCPAC) Review Board, work relative value and direct practice expense inputs for new and revised codes for CPT 2004.

These work relative value and direct practice expense input recommendations address new codes for rehabilitation assessment and integration services. Also included in the attached material are practice expense refinement recommendations for existing codes, specifically codes related to speech and language hearing procedures and several podiatric procedures which were first reviewed by the Practice Expense Advisory Committee (PEAC) and then approved by the HCPAC.

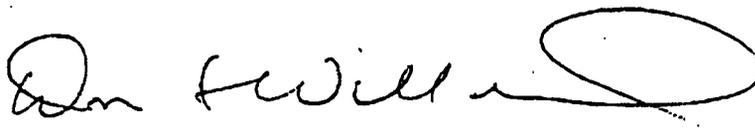
In addition to our recommendations, we would like to introduce Mary Foto, OT as the newly elected HCPAC Review Board Co-Chair. Her active participation as the American Occupational Therapy Association's RUC HCPAC Advisor since the inception of the HCPAC well prepares her for this position. Her term will begin at the September 2003 RUC HCPAC Review Board Meeting.

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

Sincerely,



Richard Whitten, MD



Don Williamson, OD

cc: Paul Rudolf, MD  
Ken Simon, MD  
Carolyn Mullen  
Pam West, PT  
Rick Ensor  
Mary Foto, OT  
Sherry Smith  
Patrick Gallagher

# CPT 2004 RUC HCPAC Review Board Recommendations

CPT Code	Global Period	Coding Change	CPT Date	CPT Issue Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Specialty	RUC Rec	Same Rec as last year?	RVU	MFS	Comments
97537	XXX	R	Aug02	W	Rehabilitation Assessment and Integration Services	F1	HCPAC	B	AOTA, APTA		0.45	0.45	Yes		Yes
97755	XXX	N	Aug02	W	Rehabilitation Assessment and Integration Services	F2	HCPAC	B	AOTA, APTA		0.62	0.62			Yes

AMA/Specialty Society RVS Update Committee  
HCPAC Review Board  
Summary of Recommendations

April 2003

**Rehabilitation Assessment and Integration Services**

Rehabilitation technology has become a significant component of medical management for persons with severe disabilities. With advantages in technology, options to assist a person with functional independence in such areas as wheeled mobility, activities of daily living, and written and verbal communication have increased exponentially. Specific skills and a knowledge base, beyond basic engineering and/or therapy are needed by a provider or practitioner to assess the functional capacity of the individual and match the functional need to a technology option. The assessment requires knowledge of disability conditions – including prognosis regarding functional issues – and knowledge of technology options designed to assist the person in meeting the functional need. Therefore, CPT Editorial Panel modified the existing code and created a new code to describe the unique nature of this rehabilitation procedure which requires specialized clinical and technical skills.

97537

The HCPAC agreed felt that the changes in the descriptor of CPT code 97537 *Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes* does not effect the work RVU of this particular code. **Therefore, the RUC HCPAC Advisory Committee recommends to maintain the 0.45 work RVU of CPT code 97537.**

97755

The RUC HCPAC Review Board examined code 97755 *Assistive technology assessment (eg, to restore, augment, or compensate for existing function, optimize functional tasks, and/or maximize environmental accessibility), with written report, each 15 minutes*. It was determined by the RUC HCPAC Review Board, after reviewing the reference code 97535 *Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment), direct one-on-one contact by provider, each 15 minutes* (Work RVU = 0.45), that although the intra service time of the two procedures are the same (intra-service time = 15 minutes), the surveyed code required more mental effort and judgement. The surveyed code, 97755, was also deemed more intense than its reference code. However, when physical therapy convened an expert panel to validate the survey data, the members of the expert panel felt that because of the respondents' lack of experience with relative values, the median RVU was not appropriate. Therefore, the society recommends the 25<sup>th</sup> percentile RVW for 97755, 0.62, as it

reflects the appropriate comparison to 97535 and other existing PM&R codes. **The RUC HCPAC Review Board recommends a work relative value of 0.62 for 97755.**

Practice Expense

The practice expense inputs for 97755 presented by the society were modified to follow the PEAC accepted standards for clinical labor times, supplies and equipment. These modifications included reductions within the clinical labor times to avoid duplication within the services since a typical session is 150 minutes or code 97755 billed ten times. The modified practice expense inputs presented by the society were approved by the HCPAC and attached to this recommendation.

CPT Code (•New)	Tracking Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
▲97537	F1	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, <u>use of assistive technology device/adaptive equipment</u> ), direct one-on-one contact by provider, each 15 minutes	XXX	0.45 (No Change)
●97755	F2	Assistive technology assessment (eg, to restore, augment, or compensate for existing function, optimize functional tasks, and/or maximize environmental accessibility), with written report, each 15 minutes  <u>(To report augmentative and alternative communication devices, use 92605 or 92607)</u>	XXX	0.62

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

---

CPT Code: 97755 Tracking Number: F2 Global Period: XXX Recommended RVW: .62

**CPT Descriptor:**

Assistive technology assessment (eg, to restore, augment, or compensate for existing function, optimize functional tasks, and/or maximize environmental accessibility), with written report, each 15 minutes

---

**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:**

A 29-year-old man with a Spinal Cord Injury, C<sub>3-4</sub> level, is living at home with his wife and two children. He was recently discharged to home from the rehab hospital with a manual, reclining back, rental chair. The initial evaluation indicates a man who is ventilator dependent for respiration and has no voluntary movement other than head rotation.

**Description of Pre-Service Work:**

- Review Chart
- Obtain payment authorization from payer
- Contact referring professionals (e.g. physicians, vocational rehab counselor)
- Survey family/client re: home, environment, caregiver factors, programming
- Calibrate initial accessibility components and systems

**Description of Intra-Service Work:**

- Assess client/technology interface
- Identify and assess client's voluntary motion (e.g. oral motor strength, head/neck range of motion and strength, ocular motor control, quality of voice output and client's ability to use the accessibility components and systems).
- Test multiple systems/components to determine optimal interface between client and technology applications.
- Determine appropriateness of commercial (off-the-shelf) components/systems.
- Determine need for modification of commercial components/systems.
- Determine need for custom components/systems.
- Design custom components/system for the client.
- Evaluate environmental constraints including home, work and transportation.
- Integrate findings of client, technology and environment to determine and design modifications to environment or technology as needed to assure client's optimal functioning of technology components and systems.

**Description of Post-Service Work:**

- Review results of evaluation
  - Research technology options
  - Design technology modifications
  - Follow up with patient/family/professionals
  - Complete documentation and written report
  - Order equipment
  - Correspond with payer
- 

**SURVEY DATA:**

**Presenter(s)**

Mary Foto, OT  
Jean Minkel, PT  
Leslie Davidson, OT

**Specialty(s):**

AOTA, APTA

Sample Size: 49 Response Rate: (%): 15 Median RVW: .90

AOTA 42/175

APTA 7/145

Type of Sample (Circle One): (stratified random), panel, convenience. Explanation of sample size: Surveys sent to subset of membership who specialize in assistive tech services

25th Percentile RVW: .62 75<sup>th</sup> Percentile RVW: .98 Low: .45 High: 2.25

Median Pre-Service Time: 4.5 Median Intra-Service Time: 15.0

25th Percentile Intra-Svc Time: 3.0 75th Percentile Intra-Svc Time: 18.0 Low: 3.0 High: 78.0

Median Post-Service Time:	<u>12.0</u>	Level of Service by CPT Code	
		<u>Total Time</u>	<u>(List CPT Code &amp; # of Visits)</u>
Immediate Post Service Time:	<u>12.0</u>		
Critical Care:	<u>x</u>	<u>x</u>	
Other Hospital Visits:	<u>x</u>	<u>x</u>	
Discharge Day Mgmt.:	<u>x</u>	<u>x</u>	
Office Visits:	<u>x</u>	<u>x</u>	

**KEY REFERENCE SERVICE:**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>Work RVU</u>
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment), direct one-on-one contact by provider, each 15 minutes	XXX	.45
97770	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes		.45

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

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

*Time estimates that follow are per 15 minute unit. Data for new code computed from median survey time for 10 units. Reference code computed from RUC database (total time for 97535 = 45 minutes). Please also see discussion of reference services on attached addendum.*

**TIME ESTIMATES (Median)**

*Per 15 minute unit*

New/Revis Key  
 CPT Code: Reference  
97755 CPT Code:  
97535  
 (RUC data)

Median Pre-Time	4.5	3
Median Intra-Time	15	15

Median Immediate Post-service Time	12	3
Median of Aggregate Critical Care Times	Xxxxxxxx	xxxxxxx
Median of Aggregate Other Hospital Visit Times	Xxxxxxxx	xxxxxxx
Median Discharge Day Management Time	Xxxxxxx	xxxxxxx
Median of Aggregate Office Visit Times	Xxxxxxx	xxxxxxx

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.4	4.1
--	-----	-----

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.8	3.4
--	-----	-----

Urgency of medical decision making	3.9	3.5
------------------------------------	-----	-----

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.8	3.5
--------------------------	-----	-----

Physical effort required	3.5	3.4
--------------------------	-----	-----

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.6	3.0
---	-----	-----

Outcome depends on the skill and judgment of physician	3.6	2.9
--	-----	-----

Estimated risk of malpractice suit with poor outcome	3.7	3.0
--	-----	-----

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**

**Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	4.6	3.4
----------------------------------	-----	-----

Intra-Service intensity/complexity	4.1	2.7
------------------------------------	-----	-----

Post-Service intensity/complexity	3.6	3.1
-----------------------------------	-----	-----

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

***Please also see discussion of reference services on attached addendum.***

An expert panel representing occupational and physical therapy met to validate the survey data. The group believed that the RVU estimates were inflated relative to the RVUs for other codes in the PM&R section, due to the responders' lack of experience with coding surveys. The survey was mailed to those therapists with expertise in assistive technology and who are very familiar with the services provided. Although the expert panel believed that the responses related to comparisons with the reference codes are valid, they recommended the 25<sup>th</sup> percentile for the work RVU as more in line with the relationships to the existing PM&R values.

---

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

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

---

**FREQUENCY INFORMATION**

How was this service previously reported? 97750, 97535, 97001, 97002, 97003, 97004, 97112, 97542,  
\_(if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty AOTA \_\_\_\_\_ Commonly  Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_

Specialty APTA \_\_\_\_\_ Commonly  Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AOTA \_\_\_\_\_ Frequency 2500 \_\_\_\_\_

Specialty APTA \_\_\_\_\_ Frequency 2500 \_\_\_\_\_

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

Specialty AOTA \_\_\_\_\_ Frequency 150 \_\_\_\_\_

Specialty APTA \_\_\_\_\_ Frequency 150 \_\_\_\_\_

---

Do many physicians (therapists) perform this service across the United States?  Yes \_\_\_\_\_ No \_\_\_\_\_

AMA/Specialty Society Update Process  
RUC Summary of Recommendation  
XXX Global Period  
In Office Direct Inputs

Sample Size: n/a (see process description) \_\_\_\_\_ Response Rate: (%): n/a \_\_\_\_\_ Global Period: XXX \_\_\_\_\_

Tracking Number: F2 \_\_\_\_\_ Reference Code 1 n/a \_\_\_\_\_ Reference Code 2 n/a \_\_\_\_\_

Geographic Practice Setting %: Rural 24 Suburban 22 Urban 47 Other (participant selected more than one area or no area) 5

Type of Practice %:

- 24 Solo Practice
- 10 Single Specialty Group
- 29 Multispecialty Group
- 2 Medical School Faculty Practice Plan
- 35 Other Outpatient Therapy practice (e.g. clinics, hospital departments)

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

A consensus panel of therapists and support personnel, who consulted with additional assistive technology experts, developed the PE inputs. The PE supplies and equipment represent those that would be used for the computer assessment portion of the vignette. That is, the equipment and % of time are that used during a typical computer assessment session, and the costs of individual supply items represent expenses for one 15-minute unit.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Set up evaluation materials
- Assist client/family with intake forms and survey information
- Assure availability of potential resources for technology

Intra-Service Clinical Labor Activities:

- Prepare room with equip/supplies
- Greet and position patient
- Assist with vital signs, measurements
- Assist with patient transfers, stability/positioning during evaluation

Post-Service Clinical Labor Activities:

- Cleanup/put away materials
- Make phone calls to patient, vendors, payer

CMS's Staff Type Code*	Clinical Labor (All clinical labor done by same staff type and generally on the same day of service)	Pre-Service Time	Service Period (Day of service)	Post-Service Time (After Day of Service)	Cost Estimate and Source (if applicable)
1028	Aide/Technician (Per 15 minute unit)		12.5 (see break-out below)		

\* From CMS's Labor, Medical Supply, and Equipment List. If not listed, provide full description, estimated cost, and cost source.

CMS's Medical Supply Code*	Medical Supplies	Quantity of Supplies (per 2.5 hour session)	Units Used for Purchase	Cost Estimate and Source (Per session - 2.5 hour (150 min.))
	Straw	3		.09
	Velcro	2 ft.	10 yds. @ \$29.95	1.40 (Sammons-Preston 1-800-323-5547)
11302	Gloves	2 pr.		.24
	Alcohol	8oz.	32 oz. @ \$10.50	2.63 (AliMed - #931364000 800-225-2610)
11118	Paper towels	—7		.07
	3M polylock	2 ft.	1"x15' @ \$39.78	5.30 (7150 Consumer Care Products 920-893-4614)
	Foam	10"x 6"x 3" block	27"x 72"x 3"	2.16 (AliMed - #220300000)
				<b>\$11.89 per 150 minutes</b>

**Medical Supplies per 15 minute unit: \$1.19 (AT supply kit)**

\* From CMS's Labor, Medical Supply, and Equipment List. If not listed, provide full description, estimated cost, and cost source.

CMS's Equipment Code*	Medical Equipment (Per session - 2.5 hour (150 min.))	% of use per session	Cost Estimate and Source (if applicable)	Cost Estimate (Bundled)
E52003	IBM computer system*	100	\$2,800.00	AT Assessment Kit  \$6110.00
	Switch kit	100	\$1,910.00 Prentke Romich	
	WhitKit Evaluation Kit	100	\$1,400 Whitmyer Biomechanics	
	Dragon NaturallySpeaking software (Accessibility)**	50	\$696 ScanSoft	AT Accessibility Software \$2371.00
	HeadMaster + adapters (Accessibility)**	50	\$1,675 Prentke Romich	
CMS list	Table, work, adjustable height	100		\$2,905

\* One type of computer system and application software is listed as 100% use as a proxy for multiple systems that would be used with a patient (e.g. Macintosh, laptop, notebook).

\*\* Two typical types of accessibility software (voice and head control) are shown as proxies. During a typical session, 2-3 equivalent components/systems will be used per patient, depending on combination of features offered and patient's functional abilities.

**Type of Service: Evaluation/Management Services or Diagnostic Tests  
XXX Global Period**

**SITE OF SERVICE: In-Office**

<u>Clinical Services</u>	<u>Minutes Per typical 150 minute session ( ) per 15 minute breakout</u>	<u>Staff Type – Aide/Tech</u>
<b>Pre-Service Period</b> <i>Start: When appointment for service is made</i>		
Review/read X-ray, lab, and pathology reports	_____	RN, LPN, MTA, Other
Other Clinical Activity (please specify) Verify and coordinate availability of resources Gather intake information from family and client	<del>10</del> (1) 8 (0.8)	RN, LPN, MTA, Other <u>aide/tech</u>
<i>End: Patient arrival at office for service</i>		
<b>Service Period</b> <i>Start: Patient arrival at office for service</i>		
Greet patient/provide gowning	3 (.5)	RN, LPN, MTA, Other <u>aide/tech</u>
Obtain vital signs	3 (.5)	<u>PT Assistant</u>
Prep and position patient	<del>10</del> (1) 2 (0.2)	<u>PT Assistant</u>
Prepare room, equipment, supplies	<del>20</del> (2) 2 (0.2)	RN, LPN, MTA, Other <u>aide/tech</u>
Assist physician during exam	80 (8)	<u>PT Assistant</u>
Coordinate home or outpatient care	<del>6</del> (.5) 3 (0.3)	<u>PT Assistant</u>
Other Clinical Activity (please specify) Take measurements	6 (0.6)	<u>PT Assistant</u>
<b>End: Patient leaves office</b>		

<b>Post-Service Period</b> Start: Patient leaves office		
Phone calls between visits with patient, family, vendors to coordinate environmental tech and coordinate logistics	<del>10</del> (1) 6 (0.6)	PT Assistant
<u>Other Activity (please specify)</u> Clean room	<del>10</del> (1) <u>8</u> (0.8)	RN, LPN, MTA, Other <u>Aide/Tech</u>
End: When appointment for next office visit is made.		
<b>Totals:</b>	121 (12.5)	

# *HCPAC Codes Reviewed by PEAC*

<b>CPT Code</b>	<b>Global</b>	<b>Medium Descriptors</b>	<b>PEAC Mtg</b>
11000	000	DEBRIDEMENT, EXTENSIVE ECZEMATOUS/INFECTED SKIN; UP TO 10PCT,	September 2002
11001	ZZZ	DEBRIDEMENT, EXTENSIVE ECZEMATOUS/INFECTED SKIN; ADD'L 10PCT	September 2002
11055	000	PARING/CUTTING, BENIGN HYPERKERATOTIC LESION; SINGLE LESION	September 2002
11056	000	PARING/CUTTING, BENIGN HYPERKERATOTIC LESION; 2-4 LESIONS	September 2002
11057	000	PARING/CUTTING, BENIGN HYPERKERATOTIC LESION; > 4 LESIONS	September 2002
11730	000	AVULSION, NAIL PLATE, PARTIAL/COMPLETE, SIMPLE; SINGLE	September 2002
11732	ZZZ	AVULSION, NAIL PLATE, PARTIAL/COMPLETE, SIMPLE; ADD'L NAIL PLATE	September 2002
11750	010	EXCISION, NAIL/NAIL MATRIX, PERMANENT REMOVAL	September 2002
11752	010	EXCISION, NAIL/NAIL MATRIX, PERMANENT REMOVAL; W/ AMPUTATION,	September 2002
64550	000	APPLICATION, SURFACE (TRANSCUTANEOUS) NEUROSTIMULATOR	September 2002
90901	000	BIOFEEDBACK TRAINING, ANY MODALITY	September 2002
90911	000	BIOFEEDBACK, PERINEAL MUSCLES/ANORECTAL/URETHRAL SPHINCTER,	September 2002
92561	XXX	BEKESY AUDIOMETRY; DX	September 2002
92562	XXX	LOUDNESS BALANCE TEST, ALTERNATE BINAURAL/MONAURAL	September 2002
92563	XXX	tone decay test	September 2002
92564	XXX	SHORT INCREMENT SENSITIVITY INDEX (SISI)	September 2002
97150	XXX	THERAPEUTIC PROC(S), GROUP, 2+ INDIVIDUALS	September 2002

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
In Office Direct Inputs**

64550, 90901, 90911, 97150

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

Geographic Practice Setting %: Rural        Suburban        Urban       

Type of Practice %:        Solo Practice  
       Single Specialty Group  
       Multispecialty Group  
       Medical School Faculty Practice Plan

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

An Advisory Panel of physical therapists was convened to review the codes in the 97000 series. The Advisory Panel represented multiple levels of care where CPT coding is used. The Panel was trained in the practice expense process. The results of the Panel's efforts were further reviewed by additional clinical consultants. The data were drafted, routed to the Advisory Panel for additional comments and finalized.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre service includes the review of the documentation, plan of care and treatment goals and the effect of previous treatment. An aide will also verify the availability of resources, materials and equipment.

Intra-Service Clinical Labor Activities:

Intra-Service includes greeting and preparing the patient, preparing the room, obtaining relevant measurements and vital signs, assisting the physical therapist during the intervention, demonstration and performance verification, post treatment assistance of the patient and cleaning the room/exercise area.

Post-Service Clinical Labor Activities:

Post-Service includes recording data and results and communication with patient, family and other providers.



AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	D	E	F	G	H	I	J	K	L
2					64550		90901		90911		97150	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE			64550: Application of a TENS unit		90901: Biofeedback by any modality		90911: Biofeedback, anorectal, incl EMG		97150: Group therapy (2 or more individuals)	
4	LOCATION				In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
47	Aide				7		10		12		3	
48	PTA				6		12		39		5	
49	Office visits: Greet patient, escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results, assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care											
50	List Number and Level of Office Visits											
51	99211 16 minutes	16										
52	99212 27 minutes	27										
53	99213 36 minutes	36										
54	99214 53 minutes	53										
55	99215 63 minutes	63										
56	Other											
57												
58	Total Office Visit Time				0	0	0	0	0	0	0	0
59	Other Activity (please specify)											
60	End: with last office visit before end of global period											
61	MEDICAL SUPPLIES											
62	Alcohol swab	31101			2		2					
63	razor	11104			1		1		1			
64	tape	31514			6"		6"		6"			
65	gauze	31505			1		1		1			
66	Conducting gel	11522			1		1		1			
67	Table paper	11111			7 ft		7 ft		7 ft			
68	gown	11107					1		1		1	
69	pillow case	11112					1		1		1	
70	drape	11106					1		1		1	
71	Disposable Electrodes (2"X2") \$5.99 per pack of four, Smithand Nephew, page 130, 2002						2					
72	EMG paper (see CMS supply 71005, EKG paper, 1 sheet at \$0.08)						2		2			
73	chuck pad	11102							1			
74	External pelvic muscle electrodes (\$90 per 100, company literature and invoice)								3			
75	Vaginal/Rectal sensors for EMG unit (\$50 company literature and invoice)								1			
76	Gloves, non sterile	11302									1 pr	
77	Sanwipe	11113									1	
78	Theraband (Sammoms 2000, pg 182, in 100 yd box, 3 feet would be \$1.25)										3 feet	
79	Equipment											
80	Low mat table				15 min						9 min	
81	For 64550 - TENS units have HCPCS codes, eg E0720, and thus are not included here				0							
82	Therapist EMG System by Noraxon, USA, Inc (\$10,995, company literature)						45 min					
83	Treatment table, adjustable	E11001					45 min		60 min			
84	Pathway CTS 2000 Continence Evaluation and Training System (\$11,750 company literature)								60 min			
85	Ther ex equipment set	E92023									20 min	



**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
In-Office Direct Inputs**

CPT Long Descriptor: 92561, Bekesy audiometry; diagnostic

CPT Code Descriptor: Bekesy audiometry; diagnostic

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

An expert specialty panel from the American Speech-Language-Hearing Association met to develop the recommendations. These recommendations were then shared with another panel of experts from another national audiology society and refined.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Review patient chart and previous test results; determine plan of action for testing; and verify equipment calibration.

Intra-Service Clinical Labor Activities:

The audiologist places the patient in a sound-treated room and instructs the patient on how to respond to auditory stimuli that will be presented to the patient via earphones or ear inserts. The patient is given a push button control of a motor drive that allows for attenuation of the signal. When the patient hears a sound, he presses and holds a switch that attenuates the signal. When the tone fades away, the button is released until the tone is heard again, etc. The patient may do sweep frequency tracings (continuously changing frequency from low to high or the reverse) or do fixed frequency plotting (a selection of discrete frequencies tested individually). The patient's threshold is traced over time and recorded on a plotter. The patient first traces responses to interrupted pure tones; then the patient traces responses to continuous tones.

The audiologist interprets the tracings by comparing the continuous and interrupted tone tracings and determines which type of tracing pattern exists. There are five "types" of tracing patterns (i.e., I, II, III, IV, V), each of which suggests a different site of lesion.

Post-Service Clinical Labor Activities:

Total Staff Time In-Office: 52

Visits in Global Period:

CMS's Staff Type Code**	Clinical Labor	Pre-Service Time	Service Period	Coordination of Care*	Post-Service Time	Cost Estimate and Source (if applicable)
1003	Audiologist	2	50			

\*By staff in the physician's office during the service period.

\*\* From CMS's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

CMS's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
See below	Bekesy Paper	1 sheet	Ream	
11505	Otoscope speculum, disposable	1	Box	
31101	Alcohol swab	1	Box	

\* From CMS's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

CMS's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
See Below	Bekesy Audiometer	1	50		
E71031	Sound Booth	1	50		



Coordination of care by staff in office

Other Activity (please specify)

5

Audiologist

Interpret data

*End: Patient leaves facility or physician leaves patient's hospital unit.*

**Post-Service Period**

Start: Patient leaves facility or physician leaves patient's hospital unit.

Other Activity (please specify)

*End: When appointment for next office visit is made.*

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Out-Of-Office Direct Inputs**

CPT Long Descriptor: 92562, Loudness balance test, alternate binaural or monaural

CPT Code Descriptor: Loudness balance test, alternate binaural or monaural

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

An expert specialty panel from the American Speech-Language-Hearing Association met to develop the recommendations. These recommendations were then shared with another panel of experts from another national audiology society and refined.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Review patient chart and previous test results; determine plan of action for testing; and verify audiologic equipment calibration.

Intra-Service Clinical Labor Activities:

The audiologist places the patient in a sound-treated room and instructs the patient on how to respond to auditory stimuli that will be presented to the patient via earphones or ear inserts. The audiologist presents and controls all stimuli asking the patient for judgements of loudness. For the alternate binaural loudness balance (ABLB), the "reference ear" is the good ear and the poor ear serves as the "variable ear." For monaural loudness balance (MLB), the reference frequency would be the normal frequency and the poor frequency is the variable. The patient's task is to state whether the variable tone is "softer than," "louder than," or "equal" in loudness to the one in the reference ear.

For either method, four results are possible with the audiologist's interpretation being based on loudness judgements at the most intense level in the reference ear, while the overall pattern is of value in viewing loudness growth function. The procedure is valuable in separating cochlear from retrocochlear disorders.

Post-Service Clinical Labor Activities:

Total Staff Time Out of Office: 43

Visits in Global Period:

CMS's Staff Type Code**	Clinical Labor	Pre-Service Time	Service Period	Coordination of Care*	Post-Service Time	Cost Estimate and Source (if applicable)
1003	Audiologist	2	41			

\*By staff in the physician's office during the service period.

\*\* From CMS's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

CMS's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
11505	Otoscope speculum, disposable	1	Box	
31101	Alcohol swab	1	Box	

\* From CMS's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

CMS's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E71029	Audiometer	1	41		
E71031	Sound Booth	1	41		


\* From CMS's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

**Type of Service: Evaluation/Management and Diagnostic Tests  
XXX Global Period**

**SITE OF SERVICE: Out-of-Office**

**Clinical Services**

**Minutes**

**Staff Type – Circle**

**Pre-Service Period**

*Start: When appointment for service is made.*

Review patient chart	2	Audiologist
----------------------	---	-------------

Other Clinical Activity (please specify)

*End: Patient arrival for service or physician arrives at patient's hospital unit. (i.e.: contact between physician and patient for service)*

**Service Period**

*Start: Patient arrival for service or physician arrives at patient's hospital unit.*

Greet patient/provide gowning	3	Audiologist
-------------------------------	---	-------------

Preservice Education	2	Audiologist
----------------------	---	-------------

Prep and position patient

Prepare room, equipment, supplies	2	Audiologist
-----------------------------------	---	-------------

Perform procedure	25	Audiologist
-------------------	----	-------------

Education/instruction/ counseling	3	Audiologist
-----------------------------------	---	-------------

Coordinate home or outpatient care

Clean room/equipment	3	Audiologist
----------------------	---	-------------

Coordination of care by staff in office

Other Activity (please specify)	3	Audiologist
---------------------------------	---	-------------

Interpret data

*End: Patient leaves facility or physician leaves patient's hospital unit.*

**Post-Service Period**

Start: Patient leaves facility or physician leaves patient's hospital unit.

Other Activity (please specify)

*End: When appointment for next office visit is made.*

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Out-Of-Office Direct Inputs**

CPT Long Descriptor: 92563, Tone decay test

CPT Code Descriptor: Tone decay test

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

An expert specialty panel from the American Speech-Language-Hearing Association met to develop the recommendations. These recommendations were then shared with another panel of experts from another national audiology society and refined.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Review patient chart and previous test results; determine plan of action for testing; and verify audiologic equipment calibration.

Intra-Service Clinical Labor Activities:

The audiologist places the patient in a sound-treated room and instructs the patient on how to respond to auditory stimuli that will be presented to the patient via earphones or ear inserts. The testing involves the presentation of a sustained pure-tone signal at or above a patient's threshold. The patient is instructed to let the audiologist know whenever the tone is present and when it disappears. The intensity of the signal is increased until either (a) the person hears the tone for a specified time or (b) a given time has elapsed and/or a given increase in stimulus intensity has been reached.

The audiologist analyzes the amount of decay and the rate of decay for patterns indicative of cochlear or retrocochlear pathology.

Post-Service Clinical Labor Activities:

Total Staff Time Out of Office: 33

Visits in Global Period:

CMS's Staff Type Code**	Clinical Labor	Pre-Service Time	Service Period	Coordination of Care*	Post-Service Time	Cost Estimate and Source (if applicable)
1003	Audiologist	2	31			

\*By staff in the physician's office during the service period.

\*\* From CMS's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

CMS's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
11505	Otoscope speculum, disposable	1	Box	
31101	Alcohol swab	1	Box	

\* From CMS's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

CMS's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E71029	Audiometer	1	31		
E71031	Sound Booth	1	31		



**Post-Service Period**

Start: Patient leaves facility or physician leaves patient's hospital unit.

Other Activity (please specify)

*End: When appointment for next office visit is made.*

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
Out-Of-Office Direct Inputs**

CPT Long Descriptor: 92564, Short increment sensitivity index (SISI)

CPT Code Descriptor: Short increment sensitivity index (SISI)

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

An expert specialty panel from the American Speech-Language-Hearing Association met to develop the recommendations. These recommendations were then shared with another panel of experts from another national audiology society and refined.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Review patient chart and previous test results; determine plan of action for testing; and verify equipment calibration.

Intra-Service Clinical Labor Activities:

The audiologist places the patient in a sound-treated room and instructs the patient on how to respond to auditory stimuli that will be presented to the patient via earphones or ear inserts. The audiologist presents a steady or carrier tone to the patient. The carrier tone is presented at 20 decibels above the patient's puretone threshold for the test frequency. Small increases in intensity occur every 5 seconds. The patient reports to the audiologist whenever an increase in loudness is perceived. The test begins with several 5-decibel increments, which are typically heard by most patients, followed by 20 1-decibel increments. Typically, those with cochlear losses hear most of the 1-decibel increments. Those with normal hearing or noncochlear lesions perceive few or no increments.

Each response to a 1-decibel increment is worth 5%, with scores in the range of 0-20% being "negative," often seen with normal hearing, conductive losses or eighth nerve problems; scores of 25-65% are "questionable" and scores of 70-100% are characteristic of cochlear dysfunction.

Post-Service Clinical Labor Activities:

Total Staff Time Out of Office: 33

Visits in Global Period:

CMS's Staff Type Code**	Clinical Labor	Pre-Service Time	Service Period	Coordination of Care*	Post-Service Time	Cost Estimate and Source (if applicable)
1003	Audiologist	2	31			

\*By staff in the physician's office during the service period.

\*\* From CMS's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

CMS's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
1505	Otoscope speculum, disposable	1	Box	
31101	Alcohol swab	1	Box	

\* From CMS's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

CMS's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E71029	Audiometer	1	31		
E71031	Sound Booth	1	31		



**Post-Service Period**

Start: Patient leaves facility or physician leaves patient's hospital unit.

Other Activity (please specify)

*End: When appointment for next office visit is made.*

**AMA/Specialty Society RVS Update Committee  
PEAC Recommendation**

Attached are recommendations for CPT codes 10060, 11000, 11001, 11055-11057, 11730, 11732, 11750 and 11752.

The APMA's initial review of CPEP data was conducted in December 1997 by a panel comprised of the Health Policy Committee (14 individuals) and the Coding Committee (11 individuals). The members of the panel at the time had been in practice between 9 and 27 years and 64% practiced in urban areas, 28% practiced in suburban areas and 8% practiced in rural areas. Of the initial panel members, 48% were from the East; 24% from the Midwest; 16% from the South; and 12% from the West. In May 2002, a consensus panel of 12 individuals representing the Health Policy Committee, Health Systems Committee, Coding Committee and Practice Expense Task Force met to discuss and develop recommendations for the September 2002 meeting of the PEAC. The consensus panel members have diverse geographic practice settings, primarily urban and suburban. The majority of panel members practice either as solo practitioners or in single specialty groups. Members of multi-specialty groups were also included on the panel.

The recommendations for CPT code 10060 that were developed by APMA were shared with the American Academy of Family Physicians (AAFP) for review and input.

Recommendations for CPT code 10060 are being submitted via a separate Summary of Recommendation form. Recommendations for CPT codes 11000, 11001 and 11055-11057 appear on the same PEAC spreadsheet while those for CPT codes 11730, 11732, 11750 and 11752 appear on a second PEAC spreadsheet.

The codes included on the separate PEAC spreadsheets represent a mix of services with variations in global periods. As our recommendations demonstrate, codes 11750 and 11752 include the following pre-service clinical labor activities: complete pre-service diagnostic & referral forms; coordinate pre-surgery services, including arranging for a H&P and necessary blood work; and schedule space and equipment in a facility, including coordination of the facility's availability with the patient's schedule and specification of the equipment necessary to perform the procedure.

Intra-service clinical labor activities for codes 11000, 11001, 11055-11057, 11730, 11732, 11750 and 11752 include some or all of the following: review charts for patient history, allergies, current medications; greet patient and provide gowning; obtain vital signs, including blood pressure and temperature; provide pre-service education/obtain consent for procedure, including discussion of possible complications and other treatment options; prepare room, equipment, supplies, including opening of necessary instruments and bandages; prepare and position patient for procedure and monitor patient; sedate/apply anesthesia; assist physician in performing procedure, including passing of instruments and retraction; clean room/equipment, including washing and sterilizing all surgical instruments and removal of hazardous materials; complete diagnostic forms and lab requisitions for cultures or other specimens when appropriate and complete X-ray requisitions when bone

work is involved as in CPT code 11752; review/read X-ray, lab, and pathology reports; check dressings for excessive bleeding and to ensure security of dressings & discuss wound/home care instructions, including weight-bearing status, bathing, loose dressings, excessive bleeding, activity levels, pain control, use of surgical shoe vs. regular foot wear, possible home dressing changes and monitoring for signs of infection; coordinate and schedule next office visit/ provide prescriptions and discuss instructions for taking medications.

The PEAC has accepted the utilization of the RUC database for determining the number and appropriate level of evaluation and management (E&M) visits included for the post-service period. When appropriate, these visits have been incorporated into our recommendations.

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
010 or 090 Day Global Periods  
In Office Direct Inputs**

Tab 20  
Revised 9/12/02

CPT Long Descriptor: 10060 - Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: 010 \_\_\_\_\_

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
 \_\_\_\_\_ Single Specialty Group  
 \_\_\_\_\_ Multispecialty Group  
 \_\_\_\_\_ Medical School Faculty Practice Plan

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

The APMA's initial review of CPEP data was conducted in December 1997 by a panel comprised of the Health Policy Committee (14 individuals) and the Coding Committee (11 individuals). The members of the panel at the time had been in practice between 9 and 27 years and 64% practiced in urban areas, 28% practiced in suburban areas and 8% practiced in rural areas. Of the initial panel members, 48% were from the East; 24% from the Midwest; 16% from the South; and 12% from the West. In May 2002, a consensus panel of 12 individuals representing the Health Policy Committee, Health Systems Committee, Coding Committee and Practice Expense Task Force met to discuss and develop recommendations for the September 2002 meeting of the PEAC. The consensus panel members have diverse geographic practice settings, primarily urban and suburban. The majority of panel members practice either as solo practitioners or in single specialty groups. Members of multi-specialty groups were also included on the panel.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: Complete pre-service diagnostic & referral forms

Intra-Service Clinical Labor Activities: review charts for patient history, allergies, current medications; greet patient and provide gowning; obtain vital signs, including blood pressure and temperature; provide pre-service education/obtain consent for procedure, including discussion of possible complications and other treatment options; prepare room, equipment, supplies, including opening of necessary instruments and bandages; prepare and position patient for procedure and monitor patient; assist physician in performing procedure, including passing of

CPT Code: 10060

Specialty Society('s) APMA

instruments and retraction; clean room/equipment, including washing and sterilizing all surgical instruments and removal of hazardous materials; complete diagnostic forms and lab requisitions for cultures or other specimens; check dressings for excessive bleeding and to ensure security of dressings & discuss wound/home care instructions, including weight-bearing status, bathing, loose dressings, excessive bleeding, activity levels, pain control, use of surgical shoe vs. regular foot wear, possible home dressing changes and monitoring for signs of infection; coordinate and schedule next office visit/provide prescriptions and discuss instructions for taking medications.

Post-Service Clinical Labor Activities: one post-operative visit.

## Visits in Global Period: 1

CMS's Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)**	Number of Office Visits	Total Time of Office Visits	Cost Estimate and Source (if appropriate)
1130	RN/LPN/MA	0	44	3	1	27	

\* From CMS's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

CMS's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if appropriate)
	Minimum visit package	2		
11306	Mask, surgical	1		
11504	Disposable scalpel # 11, 15, 20 blade	1		
14001	Sterile drape 22" x 25"	0		
14005	Gloves, sterile	1		
14007	Drape, sterile, fenestrated, 16" x 29"	1		
31101	Swab, alcohol	2		
31507	Gauze, sterile 3 x3	4		
31508	Gauze, sterile 4x4 (10 pack)	0		
31509	Kling roller bandage 2 x 131	1 items		
NEW (Gill Podiatry)	Adaptic	1	50	.55
	Needle stick safety device	1		
51504	Xylocaine w/epinephrine 1%, 20 ml	20		
51305	Ethyl chloride	1 ounce		
52301	Betadine	10 ml		
52303	Hydrogen peroxide	20 ml		
91407	Syringe, 10 cc or 12 cc	1		
91427	Needle 30 g	1		
91402	Needle, 18 to 24 gauge	1		

\* From CMS's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

CPT Code: 10060

Specialty Society('s) APMA

CMS's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E11003	Power table		71		
E30006	Exam lamp		71		

\* From CMS's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

**TYPE OF SERVICE: Surgical Procedures  
010 and 090 Global Periods**

**SITE OF SERVICE: In-OFFICE**

**Clinical Services**

**Minutes      Staff Type – Circle**

**Pre-Service Period**

*Start: Following visit when decision for surgery or procedure made*

Complete pre-service diagnostic & referral forms	<u>0</u>	RN, LPN, MA, Other _____
Coordinate pre-surgery services	<u>0</u>	RN, LPN, MTA, Other _____
Schedule space and equipment in facility	<u>0</u>	RN, LPN, MTA, Other _____
Provide pre-service education/obtain consent	<u>0</u>	RN, LPN, MTA, Other _____
Follow-up phone calls & prescriptions	<u>0</u>	RN, LPN, MTA, Other _____
Other Activity (please specify) _____	<u>0</u>	RN, LPN, MTA, Other _____

*End: When patient enters office for surgery/procedure*

**Service Period**

*Start: When patient enters office for surgery/procedure  
Pre-service services*

Review charts	<u>2</u>	RN, LPN, MTA, Other _____
Greet patient and provide gowning	<u>3</u>	RN, LPN, MTA, Other _____
Obtain vital signs	<u>3</u>	RN, LPN, MTA, Other _____
Provide pre-service education/obtain consent	<u>7</u>	RN, LPN, MTA, Other _____
Prepare room, equipment, supplies	<u>3</u>	RN, LPN, MTA, Other _____
Prepare and position patient/ monitor patient/ set up IV	<u>3</u>	RN, LPN, MTA, Other _____
Sedate/apply anesthesia	<u>  </u>	RN, LPN, MTA, Other _____

CPT Code: 10060  
Specialty Society('s) APMA

*Intra-service*

Assist physician in performing procedure

13 RN, LPN, MTA, Other  
\_\_\_\_\_

*Post-service*

Monitor pt. following service/check tubes, monitors, drains	_____	RN, LPN, MTA, Other
Clean room/equipment	<u>  3  </u>	RN, LPN, MTA, Other
Complete diagnostic forms, lab & X-ray requisitions	<u>  2  </u>	RN, LPN, MTA, Other
Review/read X-ray, lab, and pathology reports	_____	RN, LPN, MTA, Other
Check dressings & wound/ home care instructions/coordinate office visits/prescriptions	<u>  5  </u>	RN, LPN, MTA, Other
Other Activity (please specify)	_____	_____
_____	_____	RN, LPN, MTA, Other

*End: Patient leaves office*

**Post-Service Period**

*Start: Patient leaves office*

Conduct phone calls/call in prescriptions	<u>  3  </u>	RN, LPN, MTA, Other
<i>Office visits</i>		
Greet patient, escort to room		
Provide gowning		
Interval history & vital signs & chart		
Assemble previous test reports/results		
Assist physician during exam		
Assist with dressings, wound care, suture removal		
Prepare Dx test, prescription forms		
Post service education, instruction, counseling		
Clean room/equip, check supplies		
Coordinate home or outpatient care	A <u> 27 </u>	RN, LPN, MTA, Other

**List total number of office visits**

B   1  

**Total office visit time (A \* B)**

  27  

Conduct phone calls between office visits	_____	RN, LPN, MTA, Other
Other Activity (please specify)	_____	_____
_____	_____	RN, LPN, MTA, Other

*End: With last office visit before end of global period*

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
010 or 090 Day Global Periods  
Out-Of-Office Direct Inputs**

Tab 20

Revised 9/12/02

CPT Long Descriptor: 10060 - Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single

Sample Size: \_\_\_\_\_ Response Rate: (%): \_\_\_\_\_ Global Period: 010 \_\_\_\_\_

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
 \_\_\_\_\_ Single Specialty Group  
 \_\_\_\_\_ Multispecialty Group  
 \_\_\_\_\_ Medical School Faculty Practice Plan

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

The APMA's initial review of CPEP data was conducted in December 1997 by a panel comprised of the Health Policy Committee (14 individuals) and the Coding Committee (11 individuals). The members of the panel at the time had been in practice between 9 and 27 years and 64% practiced in urban areas, 28% practiced in suburban areas and 8% practiced in rural areas. Of the initial panel members, 48% were from the East; 24% from the Midwest; 16% from the South; and 12% from the West. In May 2002, a consensus panel of 12 individuals representing the Health Policy Committee, Health Systems Committee, Coding Committee and Practice Expense Task Force met to discuss and develop recommendations for the September 2002 meeting of the PEAC. The consensus panel members have diverse geographic practice settings, primarily urban and suburban. The majority of panel members practice either as solo practitioners or in single specialty groups. Members of multi-specialty groups were also included on the panel.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: complete pre-service diagnostic & referral forms; coordinate pre-surgery services, including arranging for a H&P and necessary blood work; and schedule space and equipment in a facility, including coordination of the facility's availability with the patient's schedule and specification of the equipment necessary to perform the procedure.

Intra-Service Clinical Labor Activities: None

Post-Service Clinical Labor Activities: One post-operative visit

Total Staff Time Out of Office: 57

Visits in Global Period: 1

CMS's Staff Type Code***	Clinical Labor	Pre-Service Time Prior to Admission	Service Period (Admission to Discharge)	Coordination of Care*	Post-Service Time After Discharge**	Number of Office Visits	Total Time of Office Visits	Cost Estimate Source (applicable)
1130	RN/LPN/MA	30				1	27	

\*By staff in the physician's office during the service period.

\*\*Excluding Time of Office Visits

\*\*\* From CMS's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

CMS's Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
	Minimum supply package for visits	1		
	Hydrogen Peroxide	10 ml		
	Gauze, sterile 3 x 3	6		
	Kling roller bandage 2 x 131	1		
	Betadine	10 ml		

\* From CMS's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

CMS's Equipment Code*	Medical Equipment	No. of units in practice	Minutes of use per procedure	Hours per week in use for all services	Cost Estimate and Source (if applicable)
E11003	Power table		27		
E30006	Exam lamp		27		

\* From CMS's Labor, Medical Supply, and Equipment List for year 2000. If not listed, please provide full description, estimated cost, and cost source.

**TYPE OF SERVICE: Surgical Procedures  
010 and 090 Global Periods**

**SITE OF SERVICE: OUT-OF-OFFICE**

**Clinical Services**

**Minutes      Staff Type – Circle**

**Pre-Service Period**

Start: Following visit when decision for surgery or procedure made

- |  |              |                     |
|--|--------------|---------------------|
| Complete pre-service diagnostic & referral forms | _____5_____  | RN, LPN, MTA, Other |
| Coordinate pre-surgery services                  | _____10_____ | RN, LPN, MTA, Other |
| Schedule space and equipment in facility         | _____5_____  | RN, LPN, MTA, Other |

CPT Code: 10060

Specialty Society('s) APMA

Office visit before surgery/procedure Review test and exam results	<u>    </u>	RN, LPN, MTA, Other
Provide pre-service education/obtain consent	<u>  7  </u>	RN, LPN, MTA, Other
Follow-up phone calls & prescriptions	<u>  3  </u>	RN, LPN, MTA, Other
Other Activity (please specify)	<u>  0  </u>	RN, LPN, MTA, Other

End: *When patient enters hospital for surgery/procedure*

**Service Period**

Start: *Patient admitted to hospital for surgery/procedure*  
Pre-service services

Review charts	<u>    </u>	RN, LPN, MTA, Other
Greet patient and provide gowning	<u>    </u>	RN, LPN, MTA, Other
Obtain vital signs	<u>    </u>	RN, LPN, MTA, Other
Provide pre-service education/obtain consent	<u>    </u>	RN, LPN, MTA, Other
Prepare room, equipment, supplies	<u>    </u>	RN, LPN, MTA, Other
Prepare and position patient/ monitor patient/ set up IV	<u>    </u>	RN, LPN, MTA, Other
Sedate/apply anesthesia	<u>    </u>	RN, LPN, MTA, Other
<i>Intra-service</i>		
Assist physician in performing surgery/procedure	<u>    </u>	RN, LPN, MTA, Other

*Post-service*

Monitor pt. following service/check tubes, monitors, drains	_____ RN, LPN, MTA, Other
Clean room/equipment by physician staff	_____ RN, LPN, MTA, Other
Assist with ICU or hospital visits	_____ RN, LPN, MTA, Other
<b>Total Number of ICU visits</b>	_____
<b>Total Number of hospital visits</b>	_____
Complete diagnostic forms, lab & X-ray requisitions	_____ RN, LPN, MTA, Other
Review/read X-ray, lab, and pathology reports	_____ RN, LPN, MTA, Other
Discharge day management services, check dressings & wound/ home care instructions/coordinate office visits/prescriptions	_____ RN, LPN, MTA, Other
Coordination of care by staff in office	_____ RN, LPN, MTA, Other
Other Activity (please specify)	_____
_____	_____ RN, LPN, MTA, Other

*End: Patient discharge from hospital*

**Post-Service Period**

*Start: Patient discharge from hospital*

Conduct phone calls/call in prescriptions	_____ RN, LPN, MTA, Other
Office visits	
Greet patient, escort to room	
Provide gowning	
Interval history & vital signs & chart	
Assemble previous test reports/results	
Assist physician during exam	
Assist with dressings, wound care, suture removal	
Prepare Dx test, prescription forms	
Post service education, instruction, counseling	
Clean room/equip, check supplies	
Coordinate home or outpatient care	A _____ RN, LPN, MTA, Other

**List total number of office visits**

\_\_\_\_\_ 27 \_\_\_\_\_  
 B 1 \_\_\_\_\_

**Total office visit time (A \* B)**

\_\_\_\_\_ 27 \_\_\_\_\_

Conduct phone calls between office visits	_____ RN, LPN, MTA, Other
---	---------------------------

Other Activity (please specify)	_____
_____	_____ RN, LPN, MTA, Other

*End: With last office visit before end of global period*







AMA/Specialty Society RVS Update Committee Recommendations

	A	B	M	N
1	Tab 20 - revised 9/12/02			
2			CPT Code	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	11057 - Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than four lesions	
4	LOCATION		In Office	Out Office
5	GLOBAL PERIOD		0	0
6	TOTAL CLINICAL LABOR TIME	1130	35.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		35.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		0.0	0.0
10	PRE-SERVICE			
11	Start: Following visit when decision for surgery or procedure made			
12	Complete pre-service diagnostic & referral forms			
13	Coordinate pre-surgery services			
14	Schedule space and equipment in facility			
15	Office visit before surgery/procedure: Review test and exam results			
16	Provide pre-service education/obtain consent			
17	Follow-up phone calls & prescriptions			
18	Other Clinical Activity (please specify)			
19	End: When patient enters office/facility for surgery/procedure			
20	SERVICE PERIOD			
21	Start: When patient enters office/facility for surgery/procedure			
22	Pre-service services			
23	Review charts		3	
24	Greet patient and provide gowning		3	
25	Obtain vital signs		3	
26	Provide pre-service education/obtain consent		4	
27	Prepare room, equipment, supplies		3	
28	Prepare and position patient/ monitor patient/ set up IV		3	
29	Sedate/apply anesthesia			
30	Intra-service			
31	Assist physician in performing procedure		10	
32	Post-Service			
33	Monitor pt. following service/check tubes, monitors, drains			
34	Clean room/equipment by physician staff		3	
35	Complete diagnostic forms, lab & X-ray requisitions			
36	Review/read X-ray, lab, and pathology reports			
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions		3	
38	Phone call			
39	Coordination of Care			
40	Discharge day management 99238 --12 minutes			
41	99239 --15 minutes			
42	Other Clinical Activity (please specify)			
43	End: Patient leaves office			
44	POST-SERVICE Period			
45	Start: Patient leaves office/facility			
46	Conduct phone calls/call in prescriptions			

AMA/Specialty Society RVS Update Committee Recommendations

	A	B	M	N
2			CPT Code	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	11057 - Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than four lesions	
4	LOCATION		In Office	Out Office
46	Office visits: Greet patient, escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results; assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care			
47	List Number and Level of Office Visits			
48	99211 16 minutes	16		
49	99212 27 minutes	27		
50	99213 36 minutes	36		
51	99214 53 minutes	53		
52	99215 63 minutes	63		
53	Other			
54				
55	Total Office Visit Time		0	0
56	Other Activity (please specify)			
57	End: with last office visit before end of global period			

AMA/Specialty Society RVS Update Committee Recommendations

	A	B	M	N
2			CPT Code	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	11057 - Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than four lesions	
4	LOCATION		In Office	Out Office
58	MEDICAL SUPPLIES			
59	gown, staff, impervious	11304		
60	mask, surgical with shield	11306		
61	disposable scalpel # 11, 15, 20 blade	11504	1	
62	sterile drape, 22" x 25"	14001		
63	gloves, sterile	14005	1	
64	swab, alcohol	31101	2	
65	gauze, sterile 4x4	31505		
68	gauze, sterile 3x3	31507		
67	gauze, sterile 4x4 (10 pack)	31508		
68	kling roller bandage 2x131	31509		
69	adaptic (Gill Podiatry) @ .55/each	NEW		
70	xylocaine w/epinephrine 1%, 20 ml	51504		
71	ethyl chloride	51305		
72	betadine	52301		
73	hydrogen peroxide	52303		
74	lumicaine (Gill Podiatry) @ .13/cc	NEW		
75	syringe, 10 cc or 12 cc	91407		
78	needle, 18 to 24 gauge	91402		
77	needle 30 g	91427		
78	patient gown, disposable	11107		
79	exam table paper	11111	7 feet	
80	pillow case	11112	1	
81	gloves, non-sterile	11302	2	
82	slippers, disposable (pair)	11105	1	
83	thermometer probe cover, disposable	11509		
84	Pedi pre-tape spray (Gill Podiatry) @ 1.08/ounce	NEW	1 ounce	
85	Elastoplast elastic tape (Gill Podiatry) @ .35/ft	NEW	6"	
86	Adhesive foam 1/8" (Gill Podiatry) @ 1.25/ft	NEW	8"	
87	Fabco 2" (Gill Podiatry) @ 2.28/roll	NEW	6"	
88	Semmes-Weinstein monofilament (Medical Monofilament Manufacturing, LLC) @ .23/monofilament	NEW	1	
89				
90				
91				
92				
93				
94	Equipment			
95	Power table	E11003	35	
96	Exam lamp	E30006	35	
97				
98				
99				
100				
101				
102				
103				















AMA/Specialty Society RVS Update Committee Recommendation

	A	B	M	N
1	Tab 20 - Revised 9/12/02			
2			CPT Code	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor	
4	LOCATION		In Office	Out Office
5	GLOBAL PERIOD			
6	TOTAL CLINICAL LABOR TIME		0.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		0.0	0.0
10	PRE-SERVICE			
11	Start: Following visit when decision for surgery or procedure made			
12	Complete pre-service diagnostic & referral forms			
13	Coordinate pre-surgery services			
14	Schedule space and equipment in facility			
15	Office visit before surgery/procedure: Review test and exam results			
16	Provide pre-service education/obtain consent			
17	Follow-up phone calls & prescriptions			
18	Other Clinical Activity (please specify)			
19	End: When patient enters office/facility for surgery/procedure			
20	SERVICE PERIOD			
21	Start: When patient enters office/facility for surgery/procedure			
22	Pre-service services			
23	Review charts			
24	Greet patient and provide gowning			
25	Obtain vital signs			
26	Provide pre-service education/obtain consent			
27	Prepare room, equipment, supplies			
28	Prepare and position patient/ monitor patient/ set up IV			
29	Sedate/apply anesthesia			
30	Intra-service			
31	Assist physician in performing procedure			
32	Post-Service			
33	Monitor pt. following service/check tubes, monitors, drains			
34	Clean room/equipment by physician staff			
35	Complete diagnostic forms, lab & X-ray requisitions			
36	Review/read X-ray, lab, and pathology reports			
37	Check dressings & wound/ home care instructions			
38	Phone call			
39	Coordination of Care			
40	Discharge day management 99238 --12 minutes			
41	99239 --15 minutes			
42	Other Clinical Activity (please specify)			
43	End: Patient leaves office			
44	POST-SERVICE Period			
45	Start: Patient leaves office/facility			
46	Conduct phone calls/call in prescriptions			

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	M	N
2			CPT Code	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor	
4	LOCATION		In Office	Out Office
46	Office visits: Greet patient, escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results; assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies, coordinate home or outpatient care			
47	List Number and Level of Office Visits			
48	99211 16 minutes	16		
49	99212 27 minutes	27		
50	99213 36 minutes	36		
51	99214 53 minutes	53		
52	99215 63 minutes	63		
53	Other			
54				
55	Total Office Visit Time		0	0
56	Other Activity (please specify)			
57	End: with last office visit before end of global period			
58	MEDICAL SUPPLIES			
59				
60	minimum supply pack			
61	gown, staff, impervious, disposable	11304		
62	surgical mask, with face shield	11301		
63	surgical cap	11305		
64	disposable scalpel # 11, 15, 20 blade	11504		
65	sterile drape, 22" x 25"	14001		
66	gloves, sterile	14005		
67	drape, sterile, fenestrated, 16" x 29"	14007		
68	drape, sterile mayo	14003		
69	towel, sterile	14004		
70	Hibiciens sponge/brush (Gill Podiatry) @ 1.11/each	NEW		
71	swab, alcohol	31101		
72	gauze, sterile 4x4	31505		
73	gauze, sterile 3x3	31507		
74	gauze, sterile 4x4 (10 pack)	31508		
75	klings roller bandage 2x131	31509		
76	adaptic (Gill Podiatry) @ .55/each	NEW		
77	gel foam 2" x 3"	31519		
78	steri-strips	31513		
79	disposable suture kit	31701		
80	suture removal kit	31703		
81	suture, nylon, 3-0, 4-0, 5-0	31704		
82	needle, electrosurgical	31706		
83	xylocaine 1%, 20 ml	51503		
84	bupivacaine .25%	51510		
85	ethyl chloride	51305		
86	betadine	52301		
87	hydrogen peroxide	52303		
88	saline flush	99148		
89	synnige, 10 cc or 12 cc	91407		
90	lumicaine (Gill Podiatry) @ .13/cc	NEW		
91	syringe, 20 cc	91409		

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	M	N
2			CPT Code	
3		CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Code Descriptor	
4	LOCATION		In Office	Out Office
92	needle, 30 g	91427		
93	needle, 18 to 24 gauge	91402		
94	slippers, disposable (pair)	11105		
95	Tourni-cot (Gill Podiatry) @ 2.35/each	NEW		
96	Silvadene cream (Gill Podiatry) @ .33/gram	NEW		
97	Coban, 3" (Gill Podiatry) @ 2.35/roll	NEW		
98	cotton-tipped applicators	31103		
99	61" Beaver mini-blade (Gill Podiatry) @ 2.64/each	NEW		
100	bovie pad			
101	needle stick safety device			
102	Penrose Drain	11131		
103	Equipment			
104	Power table			
105	Exam lamp			
106	Foot and ankle surgery instrument pack	E30021		
107	bovie			
108				
109				
110				
111				
112				
113				
114				
115				
116				
117				
118				
119				
120				
121				
122				
123				
124				
125				
126				
127				
128				
129				
130				
131				
132				
133				
134				
135				
136				
137				
138				
139				
140				
141				
142				
143				
144				
145				
146				
147				
148				

## **Other Issues Reviewed by the RUC**

### Non-Biodegradable Androgen Suppression Implants

Codes 11981, 11982, and 11983 first appeared in CPT 2002, and were developed to describe insertion, removal, and removal with reinsertion of a non-biodegradable drug delivery implant. These codes were initially created to describe a once-yearly implant containing leuprolide acetate for the treatment of prostate cancer. However, because various types of medications for various indications can be administered using this type of implant, the CPT Editorial Panel kept the descriptors generic. At the April 2001 RUC meeting, the RUC recommended cross-walking the RVUs from CPT codes 11975, 11976, and 11977, insertion, removal and removal with reinsertion of implantable contraceptive capsules. In 2002 the RUC again reviewed the issue and agreed to the interim crosswalk, but requested the specialty to conduct surveys for these codes and present a recommendation to the RUC at a future meeting.

During the September, 2003 RUC meeting the specialty explained to the RUC that a valid RUC survey could not be completed since the descriptors are too generic and not specific to urology. The specialty explained that it will submit a code change proposal to CPT requesting the insertion of a specific drug name into the descriptors.

The RUC discussed the potential difficulties involved in adding specific drug names to the code descriptor since it is the policy of CPT not to include proprietary drug or device names. The specialty may be faced with developing descriptors more specific to urology, but without a specific drug name reference.

The RUC also discussed how the need to recognize specific practice expenses should influence coding. Several RUC members were concerned that if CPT codes were developed for specific drugs or specific devices there would be a substantial increase in the number of CPT codes. This could lead to a situation where instead of having a single code, there would be multiple codes that differed only according to the device or drug used. The RUC discussed that one possible solution would be to maintain generic CPT codes, but foster the creation of drug or device specific HCPCs codes if there is really a need to differentiate among medical devices or drugs due to cost differences. The RUC requested that the Research Subcommittee begin to study this issue.

### Bone Marrow Procedures

During the September, 2003 RUC meeting, the RUC developed interim recommendations for a series of bone marrow procedure codes. (code 38207 – 38215) However; CMS did not publish RVUs for these procedures since CMS is unsure about the extent of physician work involved in the codes. The specialty society has been in contact with CMS and is working on arranging site visits for CMS officials to observe the procedures. Since the RUC interim recommendation is valid for one year, the specialty requested an extension of the RUC interim recommendation while it continues its discussions with CMS. The RUC approved the following motion:

**The RUC agrees to continue the interim recommendations for the bone marrow procedures codes (code 38207 – 38215), for another year until September 2004.**

ECG Vest

In May, 2003 CPT approved a new code 937XX to describe the set up and programming if a wearable ECG vest. Two other codes 93741 and 93742 were revised to include the wearable cardioverter-defibrillator vest. The specialty requested that the RUC recommend carrier pricing for code 937XX because the ACC has been unable to find a sufficient number of physicians that perform the procedure. Specifically, the manufacturer of the device provided the specialty with the names of only 17 physicians that perform the procedure. The RUC questioned the creation of the code if the procedure is not widely used and some suggested that a category III code might be more appropriate if the technology is not in widespread use. The specialty concluded that it would contact the manufacturer again and identify a larger group of physicians that would participate in the survey and present a recommendation to the RUC at either the February or April 2004 meetings.

**The RUC approved a motion to table the issue.**

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

September 2003

**Endoscopic Anti-Reflux Procedure (STRETTA) for Gastroesophageal Reflux Disease (GERD)**

A CPT code was created to reflect a new approach for treating Gastroesophageal Reflux Disease (GERD). This approach involves the delivery of endoscopically-guided, radiofrequency energy via electrodes to the distal portion of the lower esophageal sphincter and the gastric cardia.

<sup>57</sup>  
**Code 432~~XX~~**

The RUC reviewed the survey results provided by the specialty societies and observed that the societies' reference code, CPT code 43262 *Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterectomy/papillotomy* (work RVU=7.39) had significantly more pre-service time (50 Minutes) in comparison to the pre-service of the surveyed code (35 Minutes). In addition, in comparing 432XX with the reference code 43262, the RUC noted that although the intensity/complexity measures for intra-service times are comparable, the intensity/complexity measures for psychological stress were significantly less. Therefore, the RUC agrees with the specialty societies' recommendation of 5.50 work RVUs, the 25<sup>th</sup> percentile of the survey data. **The RUC recommends a work RVU of 5.50 for CPT code 432XX.**

**Practice Expense**

This service is performed in the facility setting only. The specialty society's practice expense inputs for the facility setting were accepted. These practice expense inputs are consistent with other GI Endoscopy services (e.g. CPT code 43262) approved by the PEAC and the RUC.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
▲00XXT	Upper gastrointestinal endoscopy, including esophagus, stomach, and either the duodenum and/or jejunum as appropriate, with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal	XXX	N/A

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
	<del>reflux disease</del>		
•432XX	Upper gastrointestinal endoscopy including esophagus stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease	000	5.50

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

---

CPT Code: 432XX      Tracking No: A1      Global: 000      Recommended RVW: 7.00-5.50

**Descriptor:** Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease

---

**Vignette Used in Survey:**

A 66-year-old female presents for surgery with a history of chronic heartburn and regurgitation symptoms three times or more per week, that has not responded to lifestyle management strategies and intensive daily pharmacologic therapy. She has peak esophageal peristaltic amplitude > 30 mm Hg, LESp > 5 mm Hg, complete LES relaxation in response to swallow, a DeMeester score >14.7, Hetzel grade 1 esophagitis, and no hiatal hernia > 2 cm. Under conscious sedation, an upper GI endoscopy, with delivery of radiofrequency thermal energy to the muscle of the lower esophageal sphincter and/or gastric cardia, is performed.

**Percentage of Survey Respondents who found Vignette to be Typical:**

86% Those who responded "no" indicated that their typical patients would be younger and/or male.

---

**Clinical Description Of Service:**

**Preoperative work:**

- Review pre-operative work-up, with particular attention to labs and films
- Review planned procedure
- Write pre-operative orders for peri-operative medications
- Change into scrub clothes
- Review the surgical procedure, post-op recovery, and expected outcome(s) with patient and family
- Answer patient and family questions and obtain informed consent
- Verify that all necessary instruments and supplies are readily available in the endoscopy suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown

**Intra-operative Work:**

After intravenous access is obtained and conscious sedation administered, an EGD is performed to confirm the absence of pathology that would represent a contraindication to the performance of the proposed procedure. The upper endoscope is then positioned in the gastric antrum, and a guide-wire is passed through the endoscope into the duodenum or gastric antrum. The endoscope is withdrawn while noting the distance from the incisors to the gastroesophageal junction. The thermal catheter is passed over the guide-wire and positioned 1 cm proximal to the squamocolumnar junction. The thermal catheter balloon is inflated to 2.5 psi, needle electrodes (4) deployed, and RF energy delivery commenced. This treatment is repeated after rotating the catheter 45 degrees and then again by advancing it 5 mm (4 treatments thus far). The catheter is then advanced into the stomach. An endoscope is re-introduced per-oral and passed alongside the catheter to confirm accurate positioning of the first 2 rings. The endoscope is then withdrawn. Third and fourth rings, comprised of eight lesions per ring, are then placed in 5 mm increments distal to the second ring, adjusting the measurements according to the endoscopic findings. The catheter is then advanced into the stomach, fully inflated to 25 cc of air, and withdrawn into the gastric cardia. Three such deployments and lesion sets are created, totaling 12 lesions in the distal cardia. This is repeated with a balloon inflated to 22cc, creating 12 lesions in the proximal cardia. A third EGD is performed to confirm lesion placement. The catheter is then withdrawn.

**Postoperative work:**

- Check patient's vital signs and transfer patient to recovery room
- Monitor patient for signs of complications (perforation, chest pain, nausea and/or vomiting).
- Write postoperative note in patient's chart
- Dictate procedure report
- Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company
- Consult with the family/patient regarding the surgery
- Review instructions for post-discharge diet and home care with patient and family
- Write orders for post-discharge medications
- Prepare discharge records
- Discuss procedure outcome with referring physician

**SURVEY DATA**

<b>Presenter(s):</b>	Joel Brill, MD (AGA) Michael Levy, MD (ASGE) Michael Edye, MD (SAGES)				
<b>Specialty(s):</b>	American Gastroenterological Association (AGA) American Society for Gastrointestinal Endoscopy (ASGE) Society of American Gastrointestinal Endoscopic Surgeons (SAGES)				
<b>CPT Code:</b>	432XX 57				
<b>Sample Size:</b>	50	<b>Resp n:</b>	37	<b>Resp %:</b>	74%
<b>Sample Type:</b>	Random – mailed to random selection of surgeons and gastroenterologists who completed Stretta training course				
		<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>
<b>Survey RVW:</b>		3.63	<b>5.50</b>	<b>7.00</b>	8.50
<b>Pre-Service Evaluation Time:</b>				<b>45 15</b>	
<b>Pre-Service Positioning Time:</b>				<b>10</b>	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>10</b>	
<b>Intra-Service Time:</b>		20	50	<b>60</b>	60
<b>Post-Service</b>	<b>Total Min*</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<b>0</b>				
<b>Critical Care time/visit(s):</b>	<b>0</b>				
<b>Other Hospital time/visit(s):</b>	<b>0</b>				
<b>Discharge Day Mgmt:</b>	<b>18</b>	<b>99238 x 0.5</b>			
<b>Office time/visit(s):</b>	<b>0</b>				

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE(S):**

CPT	Descriptor	'03 RVW	Glob
43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy	7.39	000

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

<b>TIME ESTIMATES (MEDIAN)</b>	Svy CPT 432XX	Ref CPT 43262(Hvd)
<b>Response count for time medians</b>	<b>37</b>	<b>17</b>
Pre-service	65-35	50
Intra-service	60	75
Same Day Immediate Post-service	0	0
Critical care	0	0
Other hospital visit	0	0
Discharge day management	18	28
Office visit	0	0
<b>TOTAL TIME</b>	<b>143 113</b>	<b>153</b>

**INTENSITY/COMPLEXITY MEASURES (MEAN)**

Response count for mean measures shown below	8	8
--	---	---

**TIME SEGMENTS**

Pre-service	4.00	4.13
Intra-service	4.13	4.38
Post-service	3.63	3.63

**MENTAL EFFORT AND JUDGMENT**

The number of possible diagnosis and/or the number of management options that must be considered	3.75	4.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	4.25
Urgency of medical decision making	2.75	4.13

**TECHNICAL SKILL/PHYSICAL EFFORT**

Technical skill required	3.86	4.63
Physical effort required	4.25	4.25

**PSYCHOLOGICAL STRESS**

The risk of significant complications, morbidity and/or mortality	3.75	4.75
Outcome depends on the skill and judgment of physician	4.13	4.75
Estimated risk of malpractice suit with poor outcome	3.88	4.50

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation.

The intra-service intensity of work for 432XX and 43262 are very similar although the exact work performed is different. 432XX requires three passes of two different endoscopes plus repeated thermal treatment applications. This is similar to the intra-service work of 43262, which includes scope introduction (albeit further into the digestive system), plus an excisional procedure (sphincterotomy/papillotomy). Pre-service workup and positioning and post-service discharge management is similar for both procedures. The IWPUT analysis on the next page indicates similar intensities for both procedures. The survey median RVW of 7.00 is recommended for 432XX. This is slightly less than the RVW for 43262, reflecting the slightly less intra/total time.



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

Specialty: gastroenterology and general surgery

Frequency: 10% of the national population would be in the Medicare patient age category.

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

---

**AMA/Specialty Society Update Process  
RUC Summary of Recommendation  
000 Day Global Periods  
Out-Of-Office Direct Inputs**

CPT	DESCRIPTOR	Global
432XX	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease	000

**Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:** A workgroup consisting of members from the AGA, ASGE, and SAGES reviewed previously approved details for other upper endoscopy codes and chose the reference code 43262 as a crosswalk for the recommendation for 432XX. This is also the same times applied to a majority of the endoscopic codes, both upper and lower.

**CLINICAL STAFF TIME:**

**Pre-service period clinical staff time:** Crosswalked from details for reference code.

**Service period clinical staff time (admission to discharge):** The assignment of 6 minutes (0.5 x 99238) for discharge management has been applied to all codes for the facility column for this outpatient procedure. This is a PEAC standard.

**Post-service period clinical staff time:** N/A

	A	B	C	D	E	
1	<b>RUC September 2003</b> <i>Data for new code 432XX were crosswalked from 43262 which was approved by the PEAC in January 2003</i>	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	<b>432XX</b> Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate, with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease		<b>PEAC APPROVED Jan 2003</b>	
2						<b>43262</b>
3						ERCP, with sphincterotomy and/or papillectomy
4	<b>LOCATION</b>		<b>Facility Only</b>		<b>Facility Only</b>	
5	<b>GLOBAL PERIOD</b>		<b>0</b>		<b>0</b>	
6	<b>TOTAL NON-CS CLINICAL LABOR TIME</b>	<b>RN/LPN/MTA</b>	<b>25</b>		<b>25</b>	
7	<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>	<b>RN/LPN/MTA</b>	<b>19</b>		<b>19</b>	
8	<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>	<b>RN/LPN/MTA</b>	<b>6</b>		<b>6</b>	
9	<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>	<b>RN/LPN/MTA</b>	<b>0</b>		<b>0</b>	
10	<b>PRE-SERVICE</b>					
11	<b>Start: Following visit when decision for procedure</b>					
12	Complete pre-service diagnostic & referral forms	<b>RN/LPN/MTA</b>	<b>3</b>		<b>3</b>	
13	Coordinate pre-surgery services	<b>RN/LPN/MTA</b>	<b>5</b>		<b>5</b>	
14	Schedule space and equipment in facility	<b>RN/LPN/MTA</b>	<b>3</b>		<b>3</b>	
15	Provide pre-service education/obtain consent	<b>RN/LPN/MTA</b>	<b>5</b>		<b>5</b>	
16	Follow-up phone calls & prescriptions	<b>RN/LPN/MTA</b>	<b>3</b>		<b>3</b>	
17	Other Clinical Activity (please specify)	<b>RN/LPN/MTA</b>				
18	<b>End: When pt enters office/facility for surgery</b>					
19	<b>SERVICE PERIOD</b>					
40	Dischg day mgmt 99238 –12 min; 99239 –15 min	<b>RN/LPN/MTA</b>	<b>6</b>		<b>6</b>	
41	<b>End: Patient leaves facility</b>					
42	<b>POST-SERVICE Period</b>		<b>N/A</b>		<b>N/A</b>	

# Special CMS Requests

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2003

**Developmental Testing Services**

96110

CPT code 96110 describes limited developmental testing, not the routine preventative medicine developmental forms. The typical scenario is a parent will call concerning their child (i.e. concern of autism) and the pediatric office will ask the parent to come in and fill out a screening form, which will be scored by a nurse. The parent would discuss this at a future scheduled visit with the pediatrician. As this code only describes the administration of the test, there is no physician work associated with this code, **the RUC recommends a work relative value recommendation of 0.00 for 96110.**

96111

The RUC examined code 96111 *Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, e.g., Bayley Scales of Infant Development) with interpretation and report, per hour*. It was determined by the RUC after reviewing the reference code 99245 *Office consultation for a new or established patient, which requires these three components: a comprehensive history; a comprehensive examination; medical decision-making of high complexity* (Work RVU = 3.43) that the intra-service time of the surveyed code (intra-service time = 85 minutes) exceeds the intra-service time of the reference service code (intra-service time = 48 minutes). In addition, the RUC noted that the survey's complexity and intensity measures for the surveyed code were often higher than the reference code. Although the descriptor for 96111 clearly states that it is a "per hour" code, the median survey intra-service time was 85 minutes, which is counterintuitive to a code designed to be reported for each 60 minutes of service. Based on this survey anomaly, the RUC agreed that the 25<sup>th</sup> percentile is the appropriate recommendation since it has both an intra-service time of 60 minutes and a survey work RVU of 2.60, which approximates the current work RVU of 99244 (2.58), a lower level consultation code than the most frequently selected reference service code (99245). In addition, the RUC requested that the specialty develop a coding proposal to CPT to delete the language "*per hour*," so that the code descriptor adequately reflects the service. The RUC felt that this code should only be reported once rather than "per hour." **The RUC recommends a work relative value of 2.60 for 96111.**

Practice Expense

The RUC modified and accepted the direct practice inputs recommended by the specialty society for these codes which were based on PEAC accepted standards. The specialty society requests that CPT code 96100 not be included in the zero work pool.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
96110		Developmental testing; limited (eg, Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report	XXX	0.00
96111		Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, e.g., Bayley Scales of Infant Development) with interpretation and report, per hour	XXX	2.60

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

---

CPT Code: 96111      Tracking Number: N/A      Global Period: XXX      Recommended RVW: 2.60

**CPT Descriptor: Developmental testing; extended (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments, eg, Bayley Scales of Infant Development) with interpretation and report, per hour**

---

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: An eight-year-old boy with impulsive, overly active behavior and previously assessed "average" intelligence was referred for evaluation of 'attention deficit disorder.' He had reading and written expression skills at the end of first grade level. The patient received speech and language therapy during his attendance at Head Start when he was four years old.

Behavior and emotional regulation rating scales (completed by the parent and another adult observer) are typically provided at the time of an earlier evaluation and management service appointment. History, physical and neurological examination are also completed at that visit. For this patient, responses from those standardized rating scales completed by his father and teacher were reviewed at that visit.

Standardized testing was administered to confirm auditory and visual attention, short term and working memory as well as verbal and visual organization. Testing was administered for standard scores as well as structured observations of behavior. These observations were integrated with previous historical data to support and confirm the diagnosis. The physical and neurologic evaluation would be part of an associated evaluation and management visit.

Description of Pre-Service Work:

Prior to the initial appointment with the pediatric developmental and behavioral subspecialist, when the child's mother called to make the appointment, she mentioned that he had early chronic ear infections and tube placement. Since then, he has seemed to have difficulty hearing what is being said. The pediatric subspecialist called the mother to discern if this had been assessed by the child's primary care physician. She denied any further assessment as the primary care physician reassured her "this may be a sign of his attention deficits." After explaining to the mother that it could be very helpful to have the primary care physician see the patient again before an appointment with the pediatric subspecialist and then obtaining her permission to contact the primary care physician, the pediatric subspecialist called the primary care physician and suggested a hearing evaluation would be appropriate prior to the requested current assessment. The primary care physician agreed. Several weeks later, the primary care physician called the pediatric subspecialist and reviewed the results of the child's hearing evaluation and asked if the referral was still acceptable. The pediatric subspecialist accepted the referral and the appointment was scheduled.

Description of Intra-Service Work:

The pediatric subspecialist chose the Woodcock-Johnson Test of Cognitive Abilities, Third Edition as this instrument allows the assessment of 'verbal abilities,' 'visual-spatial' abilities, processing speed, short-term and long-term memory composite scores. Identification of large differences in these individual areas can identify co-morbid cognitive processing areas impacting the child's ability to maintain focused selective attention. The testing session began with the subtests emphasizing auditory and verbal memory and knowledge (Memory for Words, Auditory Working Memory, Verbal Ability, General Information). Visual processing was assessed next (Picture Recognition, Spatial Relations, Planning). Processing rates for verbal information (Retrieval Fluency) and then visual/fine motor skills (Visual Matching, Decision Speed) were assessed. Finally, 'fluid processing' was observed (Concept Formation). Throughout the 75 minute session (included three 5 minute break periods for the child to go to the restroom, obtain a snack with the physician, and check with his mother while in the company of the physician), the physician noted the child's expressive discourse language skills, seated posture, fidgetiness, signs of external and internal distractibility, apparent mental effort, mood and preferences for certain tasks. Hand

position during the pencil and paper tasks and fine motor control used while opening the snack packages and 'juice box' were specifically noted. After the testing, the responses were scored and the physician reviewed the results with the patient and his mother. The explanations were directed at the child and the mother individually so that each understood the testing results. The results indicated a significant difference between Verbal Ability and Concept Formation and the Visual/Spatial Composite score. A formal assessment of receptive and expressive language was suggested. The patient's awkward pencil grip and notably slow speed during the pencil and paper tasks, taken in the context of the history provided, supported a suggested referral to an occupational therapist for consultation. Observations made during the testing confirmed the 'hyperactivity' scale observations made by the patient's teacher and mother on the rating scales obtained by the primary care physician prior to the referral.

#### Description of Post-Service Work:

After the evaluation testing appointment, the physician wrote a report (included in the work of the 96111 code) describing the results of the testing and recommendations reflective of the results. The mother called two weeks later and said the school psychologist would not schedule a meeting to review the results for eight weeks. She gave permission for full communication with all pertinent school personnel. The physician called the school psychologist to explain the need for prompt review of the test results as the patient's current classroom modifications were minimal and exacerbating his weak auditory attention. The school psychologist said the classroom teacher could make interim changes, but the physician would have to talk with her directly. The physician contacted the teacher by telephone and described the rationale for the utility of the classroom modifications. The teacher said she would implement them if the school speech pathologist agreed. Two days later the school speech pathologist called the physician directly about the recommendation for an assistive technology device (FM trainer). She said the physician would have to write a separate letter requesting this device for the patient. The physician wrote the letter.

#### SURVEY DATA

<b>Presenter(s):</b>	Lynn Wegner, MD, FAAP				
<b>Specialty(s):</b>	American Academy of Pediatrics (AAP)				
<b>CPT Code:</b>	96111				
<b>Sample Size:</b>	87	<b>Response (N):</b>	30	<b>Response (%):</b>	34%
<b>Sample Type:</b>	Panel (Members of the AAP Section on Developmental and Behavioral Pediatrics)				
	<b>Low</b>	<b>25th pctl</b>	<b>Median</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.20	2.60	3.43	3.43	3.50
<b>Pre-Service Evaluation Time:</b>	0.00	5.00	10.00	30.00	60.00
<b>Pre-Service Positioning Time:</b>	N/A	N/A	N/A	N/A	N/A
<b>Pre-Service Scrub, Dress, Wait Time:</b>	N/A	N/A	N/A	N/A	N/A
<b>Intra-Service Time:</b>	35.00	60.00	85.00	90.00	300.00
<b>Post-Service</b>	<b>Total Min*</b>		<b>CPT code / # of visits</b>		
<b>Immediate Post-time:</b>	42.50 (25 <sup>th</sup> percentile = 30.00)		N/A		
<b>Critical Care time/visit(s):</b>	N/A				
<b>Other Hospital time/visit(s):</b>	N/A				
<b>Discharge Day Mgmt:</b>	N/A				
<b>Office time/visit(s):</b>	N/A				

\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE: 99245**

<u>CPT Code</u>	<u>CPT Descriptor</u>	<u>Global</u>	<u>2003 Work RVU</u>
99245	Office consultation for a new or established patient, with requires these three key components: a comprehensive history; a comprehensive examination; medical decision-making of high complexity	XXX	3.43

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

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

Number of respondents who choose Key Reference Code: **18 out of 30 = 60%**

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 96111</u>	<u>Key Reference CPT Code: 99245</u>
Median Pre-Service Time	5.00	10.00
Median Intra-Service Time	60.00	48.00
Median Immediate Post-service Time	30.00	50.00
Median Critical Care Time		
Median Other Hospital Visit Time		
Median Discharge Day Management Time		
Median Office Visit Time		
<b>Median Total Time</b>	<b>95.00</b>	<b>108.00</b>

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgement (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.37	4.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.73	4.70
Urgency of medical decision making	4.63	4.47

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.63	4.63
Physical effort required	4.73	4.47

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.83	3.07
---	------	------

Outcome depends on the skill and judgement of physician	4.67	4.47
Estimated risk of malpractice suit with poor outcome	2.67	2.73

**INTENSITY/COMPLEXITY MEASURES**

New/Revised  
CPT Code:  
96111

Key Reference  
CPT Code:  
99245

**Time Segments (Mean)**

Pre-Service intensity/complexity	2.50	2.73
Intra-Service intensity/complexity	4.70	4.53
Post-Service intensity/complexity	2.50	2.80

**ADDITIONAL RATIONALE**

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

We conducted a panel survey of 87 physician members of the American Academy of Pediatrics (AAP) Section on Developmental and Behavioral Pediatrics. We received thirty completed surveys and analyzed the results via an expert panel made up of AAP and American Academy of Child and Adolescent Psychiatry (AACAP) representatives. This expert panel arrived at the final recommendation of 2.60, the survey's 25<sup>th</sup> percentile work RVU. This recommendation is based on the following rationale:

The descriptor for 96111 clearly states that it is a "per hour" code. However, the median survey intra-service time was 85 minutes, which is counterintuitive to a code designed to be reported for each 60 minutes of service. Based on this survey anomaly, we advocate that the 25<sup>th</sup> percentile is the appropriate recommendation since it has both an intra-service time of 60 minutes and a survey work RVU of 2.60, which approximates the current work RVU of 99244 (2.58), a lower level consultation code than the most frequently selected reference service code (99245).

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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

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

X Other reason (please explain): Service is typically reported in conjunction with an evaluation and management code

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

	<u>Global period</u>	<u>RVU</u>	<u>Pre</u>	<u>Intra</u>	<u>Post</u>
99243	XXX	1.72	5	30	31

Typical vignette when reported in conjunction with 96111:

The patient and his mother meet with the consulting physician to establish their understanding of the testing and to review the history (developmental attainment and school performance) relevant to the diagnosis "Attention Deficit Disorder-Combined Type." Since this evaluation and management visit is comprised of greater than fifty percent counseling, time is considered the key factor in selecting the level of service. The patient and the consultant begin the objective testing session (the patient's mother watches the process through an observer's window in a separate room).

	<u>Global period</u>	<u>25<sup>th</sup> percentile: RVU</u>	<u>Pre</u>	<u>Intra</u>	<u>Post</u>
96111	XXX	2.60	5	60	30

The same physician is reporting both 99243 and 96111. Since there is no overlap in services described by these codes, there is no duplication of service as provided by a single physician.

**FREQUENCY INFORMATION**

How was this service previously reported? 96111, which is presently unvalued for physician work (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

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

Specialty: Pediatrics \_\_\_\_\_ Commonly X Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_

Specialty \_\_\_\_\_ Commonly \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: Pediatrics \_\_\_\_\_ Frequency: ~25,000-30,000

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

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

Specialty: Pediatrics \_\_\_\_\_ Frequency: The RUC database reports the 1999 frequency of 96111 to be 947

Specialty \_\_\_\_\_ Frequency \_\_\_\_\_

Do many physicians perform this service across the United States? X Yes \_\_\_\_\_ No \_\_\_\_\_

**AMA/Specialty Society Update Process  
RUC Summary of Recommendation  
XXX Global Period  
In Office Direct Inputs**

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

Tracking Number: N/A                      Reference Code 1: N/A                      Reference Code 2: N/A

Geographic Practice Setting %: Rural           Suburban                           Urban     

Type of Practice %:           Solo Practice  
                                      Single Specialty Group  
                                      Multispecialty Group  
                                      Medical School Faculty Practice Plan

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

**Representatives from the American Academy of Pediatrics (AAP) and the American Psychological Association (APA) convened an expert panel to develop direct practice expense recommendations.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:                      **None**

Intra-Service Clinical Labor Activities:                      **Scoring completed developmental screening tool**

Post-Service Clinical Labor Activities:                      **None**

CMS' Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
7129	RN/LPN	0.00	15.00	0.00	

\*From CMS' Labor, Medical Supply, and Equipment List. If not listed, provide full description, estimated cost, and cost source.

CMS' Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
N/A	Ages And Stages Questionnaire (ASQ)	1 unit		\$0.40 Source: Paul J. Brookes, Publishers, PO Box 10624, Baltimore, MD 21285, 800/638-3775, <a href="http://www.pbrookes.com">www.pbrookes.com</a> ; stock #370X, \$190.00 for 19 kits but publisher allows photocopying of up to 25 additional copies of each kit for use with other patients; $\$190.00/(19 \times 25) = \$0.40$ per patient

\* From CMS' Labor, Medical Supply, and Equipment List. If not listed, provide full description, estimated cost, and cost source.

CMS' Equipment Code*	Medical Equipment	Cost Estimate and Source (if applicable)
	N/A	

**Type of Service: Evaluation/Management Services or Diagnostic Tests  
XXX Global Period**

**SITE OF SERVICE: In-Office**

**Clinical Services**

**Minutes**

**Staff Type – Circle**

**Pre-Service Period**

*Start: When appointment for service is made*

Review/read X-ray, lab, and pathology reports

\_\_\_\_\_

RN, LPN, MTA, Other

\_\_\_\_\_

Other Clinical Activity (please specify)

\_\_\_\_\_

RN, LPN, MTA, Other

\_\_\_\_\_

*End: Patient arrival at office for service*

**Service Period**

*Start: Patient arrival at office for service*

Greet patient/provide gowning

\_\_\_\_\_

RN, LPN, MTA, Other

\_\_\_\_\_

Obtain vital signs

\_\_\_\_\_

RN, LPN, MTA, Other

\_\_\_\_\_

Prep and position patient

\_\_\_\_\_

RN, LPN, MTA, Other

\_\_\_\_\_

Prepare room, equipment, supplies

\_\_\_\_\_

RN, LPN, MTA, Other

\_\_\_\_\_

Assist physician during exam

\_\_\_\_\_

RN, LPN, MTA, Other

\_\_\_\_\_

Education/instruction/ counseling

\_\_\_\_\_

RN, LPN, MTA, Other

\_\_\_\_\_

Coordinate home or outpatient care

\_\_\_\_\_

RN, LPN, MTA, Other

\_\_\_\_\_

Clean room/equipment

\_\_\_\_\_

RN, LPN, MTA, Other

\_\_\_\_\_

Other Clinical Activity (please specify):

**Scoring completed developmental screening tool**

**15**

**RN, LPN, MTA, Other**

\_\_\_\_\_

*End: Patient leaves office*

**Post-Service Period**

*Start: Patient leaves office*

Phone calls between visits with patient, family pharmacy

\_\_\_\_\_

RN, LPN, MTA, Other

\_\_\_\_\_

Other Activity (please specify)

\_\_\_\_\_

RN, LPN, MTA, Other

\_\_\_\_\_

*End: When appointment for next office visit is made.*

**AMA/Specialty Society Update Process  
RUC Summary of Recommendation  
XXX Global Period  
In Office Direct Inputs**

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

Tracking Number: N/A                      Reference Code 1: N/A                      Reference Code 2: N/A

Geographic Practice Setting %: Rural           Suburban                           Urban     

Type of Practice %:         Solo Practice  
                                      Single Specialty Group  
                                      Multispecialty Group  
                                      Medical School Faculty Practice Plan

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

**Representatives from the American Academy of Pediatrics (AAP) and the American Psychological Association (APA) convened an expert panel to develop direct practice expense recommendations.**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:                      **Phone call to patient/parent once referral from primary care physician received; review developmental screening results from primary care physician**

Intra-Service Clinical Labor Activities:                      **None**

Post-Service Clinical Labor Activities:                      **None**

CMS' Staff Type Code*	Clinical Labor	Pre-Service Time	Service Period (Day of service)	Post-Service Time After Day of Service)	Cost Estimate and Source (if applicable)
1130	RN/LPN/MTA	3.00	0.00	0.00	

\*From CMS' Labor, Medical Supply, and Equipment List. If not listed, provide full description, estimated cost, and cost source.

CMS' Medical Supply Code*	Medical Supplies	Quantity of Supplies	Units Used for Purchase	Cost Estimate and Source (if applicable)
N/A	Woodcock Johnson Test of Cognitive Abilities (WJ-TCA), Third Edition, Test Record	1 unit		\$2.44 Source: Paul J. Brookes, Publishers, PO Box 10624, Baltimore, MD 21285, 800/638-3775, <a href="http://www.pbrookes.com">www.pbrookes.com</a> ; stock #9-23610, \$61.00 for 25 kits; \$61.00 divided by 25=\$2.44 per patient

\* From CMS' Labor, Medical Supply, and Equipment List. If not listed, provide full description, estimated cost, and cost source.

CMS' Equipment Code*	Medical Equipment	Cost Estimate and Source (if applicable)
N/A	Woodcock Johnson Test of Cognitive Abilities (WJ-TCA), Third Edition, Standard Cognitive Abilites Battery and Compuscore and Profiles Program	\$727.50 Source: Paul J. Brookes, Publishers, PO Box 10624, Baltimore, MD 21285, 800/638-3775, <a href="http://www.pbrookes.com">www.pbrookes.com</a> ; stock #9-23610 and stock #9-23540

**Type of Service: Evaluation/Management Services or Diagnostic Tests  
XXX Global Period**

**SITE OF SERVICE: In-Office  
Clinical Services**

	<u>Minutes</u>	<u>Staff Type – Circle</u>
<b>Pre-Service Period</b>		
<i>Start: When appointment for service is made</i>		
Review/read X-ray, lab, and pathology reports	_____	RN, LPN, MTA, Other _____
Other Clinical Activity (please specify):		
<b>Phone call to patient/parent once referral from primary care physician received</b>	_____	RN, LPN, MTA, Other _____
<b>Review developmental screening results from primary care physician</b>	_____	RN, LPN, MTA, Other _____
<i>End: Patient arrival at office for service</i>		
<b>Service Period</b>		
<i>Start: Patient arrival at office for service</i>		
Greet patient/provide gowning	3	RN, LPN, MTA, Other _____
Obtain vital signs	_____	RN, LPN, MTA, Other _____
Prep and position patient	_____	RN, LPN, MTA, Other _____
Prepare room, equipment, supplies	_____	RN, LPN, MTA, Other _____
Assist physician during exam	_____	RN, LPN, MTA, Other _____
Education/instruction/ counseling	_____	RN, LPN, MTA, Other _____
Coordinate home or outpatient care	_____	RN, LPN, MTA, Other _____
Clean room/equipment	_____	RN, LPN, MTA, Other _____
Other Clinical Activity (please specify):	_____	RN, LPN, MTA, Other _____
<i>End: Patient leaves office</i>		
<b>Post-Service Period</b>		
<i>Start: Patient leaves office</i>		
Other Activity (please specify)	_____	RN, LPN, MTA, Other _____
<i>End: When appointment for next office visit is made.</i>		

	A	B	C	D	E	F
1						
2	Direct PE Recommendations; April 2003 RUC		96110		96111	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Developmental testing; limited, with interpretation and report		Developmental testing; extended, with interpretation and report, per hour	
4	LOCATION		In Office	Out Office	In Office	Out Office
5	GLOBAL PERIOD					
6	TOTAL CLINICAL LABOR TIME	1130 (RN/LPN/MTA)	15.0	0.0	3.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		15.0	0.0	3.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		0.0	0.0	0.0	0.0
10	PRE-SERVICE					
11	Start: Following visit when decision for surgery or procedure made					
12	Complete pre-service diagnostic & referral forms					
13	Coordinate pre-surgery services					
14	Schedule space and equipment in facility					
15	Office visit before surgery/procedure: Review test and exam results					
16	Provide pre-service education/obtain consent					
17	Follow-up phone calls & prescriptions					
18	Other Clinical Activity (please specify):					
19	Phone call to patient/parent once referral from primary care physician received					
20	Review developmental screening results from primary care physician					
21	Review/read X-ray, lab, and pathology reports					
22	End:When patient enters office/facility for surgery/procedure					
23	SERVICE PERIOD					
24	Start: When patient enters office/facility for surgery/procedure					
25	Pre-service services					
26	Review history, systems, medications					
27	Greet patient and provide gowning				3	
28	Obtain vital signs					
29	Provide pre-service education/obtain consent					
30	Prepare room, equipment, supplies					
31	Prepare and position patient					
32	Sedate/apply anesthesia					
33	Intra-service					
34	Assist physician in performing exam					
35	Education/instruction/counseling					
36	Scoring completed developmental screening tool		15			
37	Post-Service					
38	Monitor pt. following service/check tubes, monitors, drains					
39	Clean room/equipment by physician staff					
40	Complete diagnostic forms, lab & X-ray requisitions					
41	Review/read X-ray, lab, and pathology reports					
42	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					
43	Coordinate home or outpatient care					
44	Discharge day management 99238 –12 minutes 15 minutes	99239 –				
45	Other Clinical Activity (please specify)					
46	End: Patient leaves office					
47	POST-SERVICE Period					
48	Start: Patient leaves office/facility					
49						
50	Office visits: Greet patient,escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results;assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care					
51	List Number and Level of Office Visits					
52	99211 16 minutes	16				
53	99212 27 minutes	27				
54	99213 36 minutes	36				
55	99214 53 minutes	53				
56	99215 63 minutes	63				
57	Other					
58						
59	Total Office Visit Time		0	0	0	0
60	Other Activity (please specify)					
61	End: with last office visit before end of global period					

AMA Specialty Society Recommendation

	A	B	C	D	E	F
2	Direct PE Recommendations; April 2003 RUC		96110		96111	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Developmental testing; limited, with interpretation and report		Developmental testing; extended, with interpretation and report, per hour	
4	LOCATION		In Office	Out Office	In Office	Out Office
62	MEDICAL SUPPLIES					
63	Developmental screening tools:					
64	Ages And Stages Questionnaires (ASQ); \$0.40, Source: Paul J. Brookes, Publishers, PO Box 10624, Baltimore, MD 21285, 800/638-3775, www.pbrookes.com; stock #370X, \$190.00 for 19 kits but publisher allows photocopying of up to 25 additional copies of each kit for use with other patients; \$190.00/(19x25)=\$0.40 per patient		1			
65	Woodcock Johnson Test of Cognitive Abilities (WJ-TCA), Third Edition, Test Records; \$2.44, Source: Paul J. Brookes, Publishers, PO Box 10624, Baltimore, MD 21285, 800/638-3775, www.pbrookes.com; stock #9-23610, \$61.00 for 25 kits; \$61.00 divided by 25=\$2.44 per patient				1	
66						
67						
68						
69						
70	Equipment					
71	Woodcock Johnson Test of Cognitive Abilities (WJ-TCA), Third Edition, Standard Cognitive Abilities Battery and Compuscore and Profiles Program, \$727.50, Source: Paul J. Brookes, Publishers, PO Box 10624, Baltimore, MD 21285, 800/638-3775, www.pbrookes.com; stock #9-23610 and stock #9-23540				1	

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations  
October 2004

**Drug Administration Services**

The RUC reviewed work relative value recommendations and direct practice expense inputs presented by a coalition of six specialties: oncology, hematology, infectious disease, rheumatology, gastroenterology, and urology. The specialty societies informed the RUC that the survey results were only valid in reviewing the levels of intensity between services, as the respondents were not able to differentiate between the supervision of drug administration and evaluation and management services. The specialty societies developed their recommendations via a consensus panel approach, basing their recommendations on a comparison to 99211 *Level 1 office visits* (Work RVU = 0.17) and other services evaluated by the RUC.

The RUC reviewed all twenty new codes by first allocating them into three categories (hydration, TX/DX and chemotherapy). For each of these categories, anchors were developed in order to create relativity amongst the codes. The RUC first assessed the relationship between 90760 *Intravenous infusion, hydration; initial, up to one hour*, 90765 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour*, and 96413 *Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug*. The RUC agreed that 99211 serves as an appropriate anchor for CPT code 90760 *hydration*. The RUC reviewed existing code 93798 *Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)* (Work RVU= 0.28) and determined that it was an appropriate reference code for 96413 *Chemotherapy* as the physician supervision requirements are equivalent and the patient acuity and risk of adverse outcomes are similar. The RUC then based all of the recommendations for these twenty codes within a range between 0.17 and 0.28, accounting for differences in time and intensity for each service.

The RUC considered only those codes that were approved by the CPT Editorial Panel and did not include other activities, such as physician time related to treatment management or clinical staff activities related to nutrition or psychological counseling in these specific drug administration services.

A number of supporting documents are attached to this recommendations including: 1) a summary of the RUC review of drug administration; 2) an overview of the CPT coding changes for *CPT 2006*; 3) an excel spreadsheet that summarizes the RUC recommendations; 4) an excel spreadsheet predicting the utilization of the new CPT codes; 5) excel spreadsheets with direct practice expense inputs; and 6) separate documents summarizing the specialties work recommendations for each of the 20 new codes.

***Hydration***

**90760 (H1)**

The RUC examined 90760 *Intravenous infusion, hydration; initial, up to one hour*. The RUC agreed that this service had similar complexity and intensity as a 99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician* (work RVU = 0.17). In addition, the RUC agreed that the time associated with this code (7 minutes of total service time) was equal to the physician supervision time of the reference code (7 minutes of total service time). **The RUC recommends a work relative value of 0.17 for 90760.**

**90761 (H2)**

The RUC reviewed the recommendation for 90761 *Intravenous infusion, hydration; each additional hour, up to eight (8) hours*. Although this code is the second hour of hydration, the RUC agreed that there would be a need for some nurse/physician interaction. The RUC agreed that the work related to 90761 was about half of the work associated with 90760. The RUC recommends that the total physician time is 3 minutes. **The RUC recommends a work relative value of 0.09 for 90761**

***Therapeutic/Diagnostic Infusions and Injections***

**90765 (H3)**

The RUC assessed 90765 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour* and decided that in order to maintain relativity between the codes, the work RVUs for this code should be placed between the work RVUs for 90760 (recommended work RVU of 0.17) and 96413 (recommended work RVU of 0.28). After discussing the differences between all three codes, the RUC agreed that the service provided in 90765 was more closely related to 90760 than 96413 when considering the intensity and complexity of the patient, risk of complications, and likelihood that that the physician would be asked to intervene during the course of an infusion. The RUC recommends that the total physician time is 9 minutes. **The RUC recommends a work relative value of 0.21 for 90765.**

**90766 (H5)**

The RUC examined the recommendations for 90766 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)*. The RUC agreed that the agents being administered for this code would not only require additional hours of administration but also would be very different from the agents that would be administered when 90765 would be reported alone. Due to the higher levels of toxicity of these agents, there would be more nurse/physician interaction. The RUC recommends 3 minutes of total physician time. The RUC believes that the intensity of this increment of physician involvement is greater than the increment between the first and subsequent hours of hydration, and therefore, recommends only a .03 reduction in physician work between the first and second hour of infusions for therapeutic agents. **The RUC recommends a work RVU of 0.18 for 90766.**

**90767 (H4)**

The RUC reviewed the recommendations for 90767 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for primary procedure)*. After reviewing the service, the RUC agreed that when this service is reported the patient would be receiving a second hour of administration with a second drug. The RUC agreed that complications may occur with administering a second drug and there is a greater likelihood of additional nurse/physician interaction as compared to 90766 (recommended work RVUs of 0.18). The RUC recommends 6 minutes of total physician time. **The RUC recommends a work RVU of 0.19 for 90767.**

**90768 (H6)**

The RUC examined the recommendations for 90768 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure) (report only once per substance/drug, regardless of duration)*. After reviewing the service, the RUC agreed that when this service is reported the patient would be receiving two drugs at the same time, which would account for some nurse/physician interaction but less interaction than that of 90766 or 90767. Therefore the RUC agreed that the work and intensity associated with this service would be similar to 90760, the first hour of hydration, or 99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician* (work RVU=0.17). The RUC recommends 4 minutes of total physician time. **The RUC recommends a work RVU of 0.17 for 90768.**

**90772 (H7)**

The RUC assessed the recommendations for 90772 *Therapeutic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular*. The RUC identified a reference code for this service, 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); one vaccine (single or combination vaccine/toxoid)* (Work RVU=0.00, RUC Recommended Work RVU= 0.17, 7 minutes total service time) which is similar in intensity, work and time. The RUC recommends 7 minutes of total physician time. **The RUC recommends a work RVU of 0.17 for 90772.**

**The RUC reaffirms its recommendations for vaccination codes (90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); one vaccine (single or combination vaccine/toxoid)*, 90472 *Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)*, 90473 *Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)* and 90474 *Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)* ) of 0.17, 0.15, 0.17 and 0.15; respectively. All of these codes are currently valued at 0.00 work RVUs. However, the RUC urges CMS to publish work values for these services as part of the drug administration review. The RUC also acknowledges that the direct practice expense inputs for immunization administration may need to be re-reviewed. The RUC recommendations for these services are attached.**

**90774 (H9)**

The RUC assessed the RUC recommendations for 90774 *Therapeutic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug*. The RUC used magnitude estimation to determine the appropriate work RVU for this procedure. The RUC agreed that an appropriate reference code would be 90760 *Intravenous infusion, hydration; initial, up to one hour* (RUC Recommended Work RVU=0.17) The RUC deemed 90774 to be more intense and require additional time to perform (7 minutes total time for 90760 and 9 minutes of total time for 90774) as compared to 90760. **The RUC recommends a work RVU of 0.18 for 90774.**

**90775 (H10)**

The RUC examined the recommendations for 90775 *Therapeutic or diagnostic injection (specify substance or drug); each additional sequential intravenous push (List separately in addition to code for primary procedure)*. The RUC identified a reference code for

*RUC Drug Administration Recommendations – Page Five*

90775 that was similar in work and intensity, 90761 *Intravenous infusion, hydration; each additional hour, up to eight (8) hours* (RUC Recommended Work RVU=0.09). However, 90775 requires more time to perform (4 minutes total service time) than 90761 (3 minutes total service time). The RUC agreed that in order to maintain relativity, a 0.01 increment should be added to the work RVU of 90761. **The RUC recommends a work RVU of 0.10 for 90775.**

***Chemotherapy Infusions and Injections***

**96401 (H11)**

The RUC examined the recommendations for 96401 *Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic*. The RUC agreed that the service identified with this CPT code is more complex, has higher risk and has higher probability of nurse/physician interaction than 90772 (RUC Recommended Work RVU of 0.17). In addition, the RUC observed that 96401 requires more time than 90772, 9 and 7 minutes respectively. In addition, the RUC agreed that the work described in 96401 is similar to 90765, initial therapeutic/diagnostic infusion, up to one hour. **The RUC recommends a work RVU of 0.21 for 96401.**

**96402 (H12)**

The RUC reviewed the RUC recommendations for 96402 *Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic*. Upon reviewing the recommendations for this code, the RUC identified a reference service code for this procedure, 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); one vaccine (single or combination vaccine/toxoid)* (Work RVU=0.00, RUC Recommended Work RVU= 0.17, 7 minutes total service time). The RUC recommends 9 minutes of physician time related to 96402. The RUC agreed that this code should be valued between 90772 *therapeutic injection* (RUC recommended Work RVU= 0.17) and 96401 *chemotherapy injection* (RUC Recommended Work RVU=0.21). **The RUC recommends a work RVU of 0.19 for 96402.**

**96409 (H13)**

The RUC examined the recommendations for 96409 *Chemotherapy administration, subcutaneous or intramuscular; intravenous push technique, single or initial substance/drug*. The RUC agreed that in order to maintain relativity between the chemotherapy administration codes, this procedure should be relatively placed between 96401 *Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic* (RUC Recommended Work RVU=0.21) and 96413 *Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug* (RUC Recommended Work RVU=0.28). The RUC agreed that because 96409 had 2 minutes less intra service time than 96413 and 2 minutes more intra service time than 96401, the

*RUC Drug Administration Recommendations – Page Six*

work relative value recommendation should be placed directly between the work relative value recommendations for the other two codes, in order to maintain relativity. The total physician time for 96409 is 11 minutes. **The RUC recommends a work RVU of 0.24 for 96409.**

**96411(H14)**

The RUC examined the recommendations for 96411 *Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)*. When examining the recommendation for 96411, the RUC agreed that the work associated with this code was twice the amount of work associated with 90775 due to differences in intensity, complexity and total service times (4 minutes total service time for 90775 and 7 minutes total service time for 96411). **The RUC recommends a work RVU of 0.20 for 96411.**

**96413 (H15)**

The RUC examined 96413 *Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug*. The RUC agreed that 93798 *Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)* (Work RVU= 0.28) was an appropriate reference code for 96413. The RUC agreed that 93798 was a good reference code for 96413 because both services have similar intensity, complexity and involve similar physician direct supervision times (12 minutes total service time for 93798 and 13 minutes total service time for 96413). Both of these codes require supervision that may occur for more than one patient at a time. The RUC agreed that the patient acuity and risk adverse outcomes are similar for both services. **The RUC recommends a work relative value of 0.28 for 96413.**

**96415 (H16)**

The RUC examined the 96415 *Chemotherapy administration, intravenous infusion technique; each additional hour, one to eight (8) hours (List separately in addition to code for primary procedure)*. The RUC agreed that an increment of physician work (.01) above 90766 *therapeutic/diagnostic infusion, subsequent hour* would be appropriate. The RUC agreed that the work of 96415 is equivalent to 90767 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for primary procedure)* (RUC Recommended Work RVU=0.19). The RUC recommends five minutes of total physician time. **The RUC recommends a work RVU of 0.19 for 96415.**

**96416 (H17)**

The RUC reviewed 96416 *Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump* and agreed that an appropriate reference code would be 90765 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour* (RUC Recommended Work RVU= 0.21) because both codes have similar intensity, complexity and nurse/physician interaction. In addition, both codes have similar total service times, 9 minutes total service time for 90765 and 10 minutes total service time for 96416. **The RUC recommends a work RVU of 0.21 for 96416.**

**96417 (H18)**

The RUC reviewed the recommendations for 96417 *Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to one hour (List separately in addition to code for primary procedure)*. After reviewing the service, the RUC agreed that when this service was reported the patient would be receiving a second hour of administration with a second drug. The RUC agreed that because of the complications that may occur with administering a second drug, there would be additional nurse/physician interaction as compared to 96415 (recommended work RVU of 0.19). The RUC agreed that 96417 is equivalent to 90765 *Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour* (RUC Recommended Work RVU= 0.21). The RUC recommends a total of 8 minutes of physician time. **The RUC recommends a work RVU of 0.21 for 96417.**

**96521 (H24)**

The RUC reviewed 96521 *Refilling and maintenance of portable pump* and determined that this service has similar complexity, work and total service time as 96416 (Total service times for 96416, 96521 and 96522 are 10 minutes). **The RUC recommends a work RVU of 0.21 for 96521.**

**96522 (H26)**

The RUC reviewed CPT code 96522 *Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)* and determined that this service has similar complexity, work and total service times as 96416 (Total service times for 96416, 96521 and 96522 are 10 minutes). **The RUC recommends a work RVU of 0.21 for 96522.**

**96523 (H25)**

The RUC examined 96523 *Irrigation of implanted venous access device for drug delivery systems*. The RUC observed that this service had no intra-service or post service activities and only required 2 minutes on pre-service to perform. Therefore the RUC agreed comfortable using an IWPUT analysis to establish a work relative value recommendation for this code. By using IWPUT analysis, the RUC determined that 2 minutes of pre-service same day evaluation would equate to 0.04 work RVUs (2 minutes x 0.0224 = 0.04 RVUs). **The RUC recommends a work RVU of 0.04 for 96523.**

***Physician Time***

The RUC recommends that all times associated with these codes, when placed in the RUC database, include a notation to clarify that the physician times associated with these codes are direct supervision and interactions with clinical staff, rather than face-to-face with the patient.

***Practice Expense***

The RUC reviewed the practice expense inputs for the existing codes which were approved by the PEAC and subsequently by the RUC in 2002. The RUC observed that when these codes were first reviewed, a 99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician* was billed with the majority of these codes over fifty percent of the time. However, because the current CMS rules and CCI edits do not allow a 99211 to be billed with this series of codes, the RUC noted that some of the activities that were eliminated in 2002 are not appropriate to add back to these codes. In addition, the RUC's recommendations incorporate the new coding structure and the ability to capture practice expense for subsequent drug infusions. The revised practice expense inputs are attached to this recommendation.

**Therapeutic or Diagnostic Infusions (Excludes Chemotherapy)**

These codes encompass prolonged intravenous infusions:

These codes require the presence of the physician during the infusion. These codes are not to be used for intradermal, subcutaneous, intramuscular or routine IV drug injections. For these services, see 90782-90788.

These codes may not be used in addition to prolonged services codes.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
90780		Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour	XXX	N/A
+90781		each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)  <u>(Use 90781 in conjunction with code 90780)</u>  (Codes 90780 and 90781 have been deleted. To report, see 90760, 90761)	ZZZ	N/A

**Hydration, Injections, Therapeutic or Diagnostic Infusions (Excludes Chemotherapy)**

Physician work related to hydration, injection and infusion services predominantly involves treatment planning and *direct* supervision of staff.

If a significant separately identifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported utilizing modifier 25 in addition to 90765-90799. For same day E/M service a different diagnosis is not required.

If performed to facilitate the infusion or injection, the following services are included and are not reported separately:

- a. Use of local anesthesia
- b. IV start
- c. Access to indwelling IV, subcutaneous catheter or port
- d. flush at conclusion of infusion
- e. standard tubing, syringes and supplies

(For declotting a catheter or port, see 36550)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>When multiple drugs are administered, report the service(s) and the specific materials or drugs for each.</p> <p>When administering multiple infusions, injections or combinations, only one "initial" service code should be reported, unless protocol requires that two separate IV sites must be utilized. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported (e.g. the first IV push given subsequent to an initial one-hour infusion is reported using a subsequent IV push code).</p>				
<p><b>Hydration</b></p> <p>Codes 90760-90761 are intended to report a hydration IV infusion to consist of a pre-packaged fluid and electrolytes (eg, normal saline, D5-½ normal saline+30mEq KCl/liter), but are not used to report infusion of drugs or other substances. Hydration IV infusions typically require direct physician supervision for purposes of consent, safety oversight or intra-service supervision of staff. Typically such infusions require little special handling to prepare or dispose of, and staff which administer these don't typically require advanced practice training. After initial set-up, infusion typically entails little patient risk and thus little monitoring.</p>				
•90760	H1	Intravenous infusion, hydration; initial, up to one hour	XXX	0.17
•+90761	H2	<p>each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)</p> <p><u>(Use 90760 in conjunction with code 90761)</u></p> <p><u>(Report 90761 for hydration infusion intervals of greater than thirty minutes beyond one hour increments, or hydration greater than thirty minutes provided as a secondary or sequential service after a different initial infusion or chemotherapy service is provided)</u></p> <p><u>Do not report 90760 if performed as a concurrent infusion service</u></p>	ZZZ	0.09
<p><b><u>Therapeutic, Prophylactic or and Diagnostic Injections</u></b></p> <p><u>A therapeutic or diagnostic IV infusion (90765-90772) (other than hydration) is for the administration of substances/drugs. The fluid used to administer the drug(s) is incidental hydration and is not separately reportable. These services typically require direct physician supervision for any or all purposes of</u></p>				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>patient assessment, provision of consent, safety oversight and intra-service supervision of staff. Typically, such infusions require special consideration to prepare, dose or dispose of, require practice training and competency for staff who administer the infusions, and infusions require periodic patient assessment with vital sign monitoring during the infusion</p> <p>(Do not report 90760-90775 with codes (including 96401-96549) for which IV push or infusion is an inherent part of the procedure(e.g. administration of contrast material for a diagnostic imaging study))</p>				
•90765	H3	Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour	XXX	0.21
•+90766	H5	each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)	ZZZ	0.18
•+90767	H4	<p>additional sequential infusion, up to one hour (List separately in addition to code for primary procedure)</p> <p>(Report 90766, 90767 in conjunction with code 90765)</p> <p>(Report 90767 for additional hour(s) of sequential infusion)</p> <p>(Report 90766 for infusion intervals of greater than thirty minutes beyond one hour increments)</p> <p>(Report 90766 or 90767 to identify additional hour(s) of substance/drug infusion, or 90761 for hydration infusion, if provided as a secondary or subsequent service after a different initial service is provided)</p>	ZZZ	0.19
•+90768	H6	<p>concurrent infusion (List separately in addition to code for primary procedure) (report only once per substance/drug, regardless of duration)</p> <p>(Report 90768 in conjunction with code 90765 or 96413)</p>	ZZZ	0.17

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<u>Intravenous or intra-arterial push is defined as an injection/infusion of short duration (i.e. thirty minutes or less) in which the healthcare professional who administers the substance/drug is continuously present to administer the injection and observe the patient.</u>				
•90772	H7	Therapeutic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular  <u>(For administration of vaccines/toxoids, see 90471-90472)</u> <u>(Report 90772 for non-antineoplastic hormonal therapy injections)</u> <u>(Report 96401 for anti-neoplastic hormonal injection therapy)</u>	XXX	0.17
90773	H8	<i>intra-arterial</i>	XXX	No RUC recommendation
•90774	H9	intravenous push, single or initial substance/drug  <u>(90772-90774 do not include injections for allergen immunotherapy. For            allergen immunotherapy injections, see 95115-95117)</u>	XXX	0.18
+•90775	H10	each additional sequential intravenous push (List separately in addition to code for primary procedure)  <u>(Use 90775 in conjunction with code 90774)</u>  <u>(Report 90775 to report an intravenous push subsequent or concurrent to a            hydration or therapeutic/diagnostic infusion)</u>	ZZZ	0.10
•90779		Unlisted therapeutic, or diagnostic intravenous or intra-arterial, injection or infusion  <u>(For allergy immunizations, see 95004 et seq)</u>	XXX	Carrier Priced

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<b>Therapeutic, Prophylactic or Diagnostic Injections</b>				
90782		Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular  For administration of vaccines/toxoids, see 90471, 90472  (90782 has been deleted. To report, use 90772)	XXX	N/A
90783		intra-arterial  (90783 has been deleted. To report, use 90773)	XXX	N/A
90784		intravenous  (90782-90784 do not include injections for allergen immunotherapy. For allergen immunotherapy injections, see 95155-95117)  (90784 has been deleted. To report, use 90774)	XXX	N/A
90788		Intramuscular injection of antibiotic (specify)  (90788 has been deleted; to report, use 90772)  (90790-90796 have been deleted. To report, see 95990, 96408, 96414, 96420, 96425, 96440, 96450, 96530, 96545, 96549)	XXX	N/A
90799		Unlisted therapeutic, prophylactic or diagnostic injections  (For allergy immunizations, see 95004 et seq)  (90799 has been deleted. To report, use 90779)	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p><b><u>Chemotherapy Administration</u></b></p> <p><u>Procedures 96400-96549 are independent of the patient's visit.</u></p> <p><u>Chemotherapy administration codes 96400-96549 apply to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for treatment of non-cancer diagnoses (eg, cyclophosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents and other biologic response modifiers. These services can be provided by any physician. Chemotherapy services are typically highly complex and require direct physician supervision for any or all purposes of patient assessment, provision of consent, safety oversight and intra-service supervision of staff. Typically, such chemotherapy services require advanced practice training and competency for staff who provide these services; special considerations for preparation, dosage or disposal; and commonly, these services entail significant patient risk and frequent monitoring. Examples are frequent changes in the infusion rate, prolonged presence of nurse administering the solution for patient monitoring and infusion adjustments, and frequent conferring with the physician about these issues.</u></p> <p><u>If performed to facilitate the infusion or injection, the following services are included and are not reported separately:</u></p> <ul style="list-style-type: none"> <li><u>a. Use of local anesthesia</u></li> <li><u>b. IV start</u></li> <li><u>c. Access to indwelling IV, subcutaneous catheter or port</u></li> <li><u>d. flush at conclusion of infusion</u></li> <li><u>e. standard tubing, syringes and supplies</u></li> <li><u>f. Preparation of chemotherapy agent(s)</u></li> </ul> <p><u>(For declotting a catheter or port, see 36550)</u></p> <p><u>Report separate codes for each parenteral method of administration employed when chemotherapy is administered by different techniques. Medications (eg, antibiotics, steroidal agents, antiemetics, narcotics, analgesics) administered independently or sequentially as supportive management of chemotherapy administration, should be separately reported using 90760, 90761, 90765, 90767, 90766, 90768, 90772, 90773, 90774, 90775, 90799 as appropriate.</u></p> <p><u>Report both the specific service as well as code(s) for the specific substance(s) or drug(s) provided.</u></p> <p><u>When administering multiple infusions, injections or combinations, only one "initial" service code should be reported, unless protocol requires that two separate IV sites must be utilized. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported (e.g. the first IV push given subsequent to an initial one-hour infusion is reported using a subsequent IV push code).</u></p> <p><u>If a significant separately identifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported utilizing modifier 25 in addition to 96400-96549. For same day E/M service, a different diagnosis is not required.</u></p>				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Either may occur independently on any date of service, or they may occur sequentially on the same day.</p> <p>Preparation of chemotherapy agent(s) is included in the service for administration of the agent.</p> <p><i>Regional (isolation) chemotherapy perfusion should be reported using the codes for intra-arterial infusion (96420-96425). Placement of the intra-arterial catheter should be reported using the appropriate code from the Cardiovascular Surgery section. Placement of arterial and venous cannula(s) for extracorporeal circulation via a membrane oxygenator perfusion pump should be reported using code 36823. Code 36823 includes dose calculation and administration of the chemotherapy agent by injection into the perfusate. Do not report code(s) 96409-96425 in conjunction with code 36823.</i></p> <p>Report separate codes for each parenteral method of administration employed when chemotherapy is administered by different techniques. Medications (eg, antibiotics, steroidal agents, antiemetics, narcotics, analgesics, biological agents) administered independently or sequentially as supportive management of chemotherapy administration, should be separately reported using 90780-90788, as appropriate.</p> <p>(For Home Infusion services, see 99601-99602)</p>				
<p><b><u>Injection and Intravenous Infusion Chemotherapy</u></b></p>				
96400		<p><del>Chemotherapy administration, subcutaneous or intramuscular with or without local anesthesia</del></p> <p>(Code 96400 has been deleted. To report, see 96401, 96402)</p>	XXX	N/A
•96401	H11	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	XXX	0.21
•96402	H12	hormonal anti-neoplastic	XXX	0.19
▲96405		Chemotherapy administration; <del>intralesional;</del> <u>intralesional</u> , up to and including 7 lesions	000	0.52 (No Change)
▲96406		intralesional; more than 7 lesions	000	0.80 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
96408		Chemotherapy administration, intravenous, push technique  (96408 has been deleted. To report, use 96409)	XXX	N/A
▲96409	H13	intravenous, push technique, <u>single or initial substance/drug</u>	XXX	0.24
96410		intravenous infusion technique; up to one hour  (96410 has been deleted. To report, use 96413)	XXX	N/A
+•96411	H14	intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)  (Use 96411 in conjunction with code 96409)	ZZZ	0.20
+96412		infusion techniques, one to 8 hours, each additional hour (List separately in addition to code for primary procedures)  (Use 96412 in conjunction with code 96410)  (96412 has been deleted. To report, use 96415)	ZZZ	N/A
▲96413	H15	Chemotherapy administration, intravenous infusion technique; up to one hour, <u>single or initial substance/drug</u>	XXX	0.28

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
96414		<p>infusion techniques, initiation of prolonged infusion (more than 8 hours), requiring use of a portable or implantable pump</p> <p>(For refilling and maintenance of a portable pump or an implantable infusion pump or reservoir for drug delivery, see 96520, 96530)</p> <p>(96414 has been deleted. To report, use 96416)</p>	XXX	N/A
+▲96415	H16	<p>infusion technique, each additional hour, one to eight (8) hours, each additional hour (List separately in addition to code for primary procedure)</p> <p>(Use 96415 in conjunction with 96413)</p> <p>(Report 96415 for infusion intervals of greater than thirty minutes beyond one hour increments)</p> <p>(Report 90761 to identify hydration, or 90766 to identify nonchemotherapy drug infusion, if provided as a secondary or subsequent service in association with 96413)</p>	ZZZ	0.19
▲96416	H17	<p>infusion technique, initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump</p> <p>(For insertion of pump, use 36563)</p> <p>(For refilling and maintenance of a portable pump or an implantable infusion pump or reservoir for drug delivery, see 96521, 96523, 96522)</p>	XXX	0.21

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
+•96417	H18	<p>each additional sequential infusion (different substance/drug), up to one hour (<u>List separately in addition to code for primary procedure</u>)</p> <p>(Use 96417 in conjunction with code 96413; report only once per sequential infusion; report 96415 for additional hour(s) of sequential infusion)</p>	ZZZ	0.21
<b><u>Intra-Arterial Chemotherapy</u></b>				
96420	H19	Chemotherapy administration, intra-arterial; push technique	XXX	No RUC recommendation
96422	H20	infusion technique, up to one hour	XXX	No RUC recommendation
▲+96423	H21	<p>infusion technique, <u>each additional hour</u>, one to eight hours; <del>each additional hour</del> (<u>List separately in addition to code for primary procedure</u>)</p> <p>(Use 96423 in conjunction with 96422)</p> <p>(Report 96423 for infusion intervals of greater than thirty minutes beyond one hour increments)</p> <p>(For regional chemotherapy perfusion via membrane oxygenator perfusion pump to an extremity, use 36823)</p>	ZZZ	No RUC recommendation

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
96425	H22	<p>infusion technique, initiation of prolonged infusion (more than eight hours), requiring the use of a portable or implantable pump</p> <p><u>(For insertion of pump, use 36260)</u></p> <p><u>(For refilling and maintenance of a portable pump or an implantable infusion pump or reservoir for drug delivery, see 96521, 96523 or 96522)</u></p>	XXX	No RUC recommendation
<p><b>Other Chemotherapy</b></p> <p><i>(See 36555-36597 for related intravascular access services)</i></p>				
96440		<p><i>Chemotherapy administration into pleural cavity, requiring and including thoracentesis</i></p>	000	2.37 (No Change)
96445		<p><i>Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis</i></p>	000	2.20 (No Change)
96450	H23	<p><i>Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture</i></p> <p><i>(For intravesical (bladder) chemotherapy administration, see 51720)</i></p> <p><i>(For insertion of subarachnoid catheter and reservoir for infusion of drug, see 62350, 62351, 62360, 62361, 62362; for insertion of intraventricular catheter and reservoir, see 61210, 61215)</i></p> <p><i>(96500-96512 have been deleted. To report, see 96409-96416)</i></p>	000	1.53 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
96520		Refilling and maintenance of portable pump  (96520 has been deleted. To report, use 96521)	XXX	N/A
•96521	H24	Refilling and maintenance of portable pump	XXX	0.21
•96522	H26	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)  (For refilling and maintenance of an implantable infusion pump for spinal or brain drug infusion, use 95990)  (For collection of blood specimen from a completely implantable venous access device, use 36540)	XXX	0.21
•96523	H25	Irrigation of implanted venous access device for drug delivery systems  (Do not report 96523 if an injection or infusion is provided on the same day)	XXX	0.04
96530		<del>Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)</del>  <del>(For refilling and maintenance of an implantable infusion pump for spinal or brain drug infusion, use 95990)</del>  <del>(For collection of blood specimen from a completely implantable venous access device, use 36540)</del>  (96530 has been deleted. To report, use 96522)	XXX	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
96542	H27	<i>Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents</i>	XXX	0.75 (No Change)
96545		<del>Provision of chemotherapy agent</del> (96545 has been deleted.)		Carrier Priced
96549		<i>Unlisted chemotherapy procedure</i>	XXX	Carrier Priced

**AMA/Specialty Society RVS Update Committee**  
**Drug Administration Services**  
**October 4, 2004**

The American Medical Association/Specialty Society RVS Update Committee (RUC) met on September 30-October 2, 2004 and recommended relative values for a number of new and revised procedure codes to describe drug administration. The recommendations now will be sent to the Centers for Medicare and Medicaid Services (CMS) which has the final responsibility for assigning values for the new codes.

These coding revisions grew out of a provision in the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) which called for a review of the current drug administration codes. Based on that directive, the CPT Editorial Panel, which maintains and updates the coding system most Medicare codes are based on, conducted an extensive review and made substantial modifications in the drug administration codes at the panel's August 2004 meeting. The RUC, which provides advice to CMS on relative values for new and revised codes, expedited its normal process in order to permit completion of the process in time for adoption of the new codes and values next year.

In making its recommendations, the RUC considered proposed work values and practice expense inputs submitted by a coalition of specialties, including: oncology, hematology, infectious disease, gastroenterology, urology and rheumatology. These proposals were developed by consensus panels and based on previous RUC recommendations for drug administration and other services that could serve as a reference point in discussing the work and practice expense associated with the new codes for drug administration.

Although their recommendations varied by service, the specialties' proposal called for an overall increase in work relative values for drug administration services above the level one new patient office visit required in the MMA. Practice expense direct inputs (clinical staff, medical supplies and equipment) also were revised to incorporate the coding revisions and as part of these revisions, the groups proposed to add certain elements of clinical staff time that are part of a standard package utilized across other services.

The RUC, and a facilitation committee of RUC participants, spent more than 15 hours over a three day period reviewing and discussing the specialties' proposed values. In general, the RUC agreed that physician supervision and interactions with nursing staff did warrant physician work relative values for these services, and that for many of the specific codes, this work is more intense than the physician work assigned to a level one office visit. Practice expense inputs suggested by the affected specialties and accepted by the RUC generally were based on a 2002 review of these expenses by the RUC and its Practice Expense Advisory Committee (PEAC). However, the RUC will recommend several modifications to incorporate the new coding structure. For example, the clinical staff time required for mixing additional chemotherapy drugs was included in the recommendations.

Although the RUC's recommendations, if adopted by CMS, are expected to have a positive impact on drug administration payments, the degree to which these changes will offset other revenue losses associated with the MMA is not yet known. Practice expense values are the primary factor in determining payment for these services and the direct inputs suggested by the RUC are only one piece in CMS's complex formula for determining practice expense values.

The RUC's recommendations will be finalized and submitted to CMS on Friday, October 8. It is anticipated that CMS will announce its decisions regarding the RUC recommendations in the November 1, 2004 *Final Rule* for the 2005 Physician Payment Schedule.

## Medicine

### **Therapeutic or Diagnostic Infusions (Excludes Chemotherapy)**

~~These codes encompass prolonged intravenous infusions.~~

~~These codes require the presence of the physician during the infusion. These codes are not to be used for intradermal, subcutaneous, intramuscular or routine IV drug injections. For these services, see 90782-90788.~~

~~These codes may not be used in addition to prolonged services codes.~~

~~90780 Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour~~

~~†90781 each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)~~

~~(Use 90781 in conjunction with code 90780)~~

~~(Codes 90780 and 90781 have been deleted. To report, see 90760, 90761)~~

### **Hydration, Injections, Therapeutic or Diagnostic Infusions (Excludes Chemotherapy)**

Physician work related to hydration, injection and infusion services predominantly involves treatment planning and direct supervision of staff.

If a significant separately identifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported utilizing modifier 25 in addition to 90765-90779. For same day E/M service a different diagnosis is not required.

If performed to facilitate the infusion or injection, the following services are included and are not reported separately:

- a. Use of local anesthesia
- b. IV start
- c. Access to indwelling IV, subcutaneous catheter or port
- d. flush at conclusion of infusion
- e. standard tubing, syringes and supplies

(For declotting a catheter or port, see 36550)

When multiple drugs are administered, report the service(s) and the specific materials or drugs for each.

When administering multiple infusions, injections or combinations, only one "initial" service code should be reported, unless protocol requires that two separate IV sites must be utilized. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported (e.g. the first IV push given subsequent to an initial one-hour infusion is reported using a subsequent IV push code).

## Hydration

Codes 90760-90761 are intended to report a hydration IV infusion to consist of a pre-packaged fluid and electrolytes (eg, normal saline, D5-½ normal saline+30mEq KCl/liter), but are not used to report infusion of drugs or other substances. Hydration IV infusions typically require direct physician supervision for purposes of consent, safety oversight or intra-service supervision of staff. Typically such infusions require little special handling to prepare or dispose of, and staff which administer these don't typically require advanced practice training. After initial set-up, infusion typically entails little patient risk and thus little monitoring.

- 90760 (H1) Intravenous infusion, hydration; initial, up to one hour
- +90761 (H2) each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)

(Use 90760 in conjunction with code 90761)

(Report 90761 for hydration infusion intervals of greater than thirty minutes beyond one hour increments, or hydration greater than thirty minutes provided as a secondary or sequential service after a different initial infusion or chemotherapy service is provided)

Do not report 90760 if performed as a concurrent infusion service.

## Therapeutic and Diagnostic Injections

A therapeutic or diagnostic IV infusion (90765-90768) (other than hydration) is for the administration of substances/drugs. The fluid used to administer the drug(s) is incidental hydration and is not separately reportable. These services typically require direct physician supervision for any or all purposes of patient assessment, provision of consent, safety oversight and intra-service supervision of staff. Typically, such infusions require special consideration to prepare, dose or dispose of, require practice training and competency for staff who administer the infusions, and infusions require periodic patient assessment with vital sign monitoring during the infusion

(Do not report 90765-90775 with codes (including 96401-96549) for which IV push or infusion is an inherent part of the procedure (e.g. administration of contrast material for a diagnostic imaging study))

- 90765 (H3) Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour
- +90766 (H5) each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)
- +90767 (H4) additional sequential infusion, up to one hour (List separately in addition to code for primary procedure)

(Report 90766, 90767 in conjunction with code 90765)

(Report 90767 for additional hour(s) of sequential infusion)

(Report 90766 for infusion intervals of greater than thirty minutes beyond one hour increments)

(Report 90766 or 90767 to identify additional hour(s) of substance/drug infusion, or 90761 for hydration infusion, if provided as a secondary or subsequent service after a different initial service is provided)

- +90768 (H6) concurrent infusion (List separately in addition to code for primary procedure) (report only once per substance/drug, regardless of duration)

(Report 90768 in conjunction with code 90765 or 96413)

Intravenous or intra-arterial push is defined as an injection/infusion of short duration (i.e. thirty minutes or less) in which the healthcare professional who administers the substance/drug is continuously present to administer the injection and observe the patient.

- 90772 (H7) Therapeutic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

(For administration of vaccines/toxoids, see 90471-90472)

(Report 90772 for non-antineoplastic hormonal therapy injections)

(Report 96401 for anti-neoplastic hormonal injection therapy)

- 90773 (H8) intra-arterial

- 90774 (H9) intravenous push, single or initial substance/drug

(90772-90774 do not include injections for allergen immunotherapy. For allergen immunotherapy injections, see 95115-95117)

- +•90775 (H10) each additional sequential intravenous push (List separately in addition to code for primary procedure)

(Use 90775 in conjunction with code 90774)

(Use 90775 to report an intravenous push subsequent or concurrent to a hydration or therapeutic/diagnostic infusion)

- 90779 ~~Unlisted therapeutic, prophylactic or diagnostic injection, or intravenous or intra-arterial, injection or infusion~~

(For allergy immunizations, see 95004 et seq)

### **Therapeutic, Prophylactic or Diagnostic Injections**

- ~~90782 Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular~~

~~(For administration of vaccines/toxoids, see 90471-90472)~~

~~(90782 has been deleted. To report, use 90772)~~

- ~~90783 intra-arterial~~

(90783 has been deleted. To report, use 90773)

~~90784 intravenous~~

~~(90782-90784 do not include injections for allergen immunotherapy. For allergen immunotherapy injections, see 95115-95117)~~

(90784 has been deleted. To report, use 90774)

~~90788 Intramuscular injection of antibiotic (specify)~~

(90788 has been deleted; to report, use 90772)

~~(90790-90796 have been deleted. To report, see 95990, 96408-96414, 96420-96425, 96440, 96450, 96530, 96545, 96549)~~

~~90799 Unlisted therapeutic, prophylactic or diagnostic injection~~

~~(For allergy immunizations, see 95004 et seq)~~

(90799 has been deleted. To report, use 90779)

## Medicine

### Chemotherapy Administration

~~Procedures 96400-96549 are independent of the patient's visit.~~

Chemotherapy administration codes 96401-96549 apply to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for treatment of non-cancer diagnoses (eg, cyclophosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents and other biologic response modifiers. These services can be provided by any physician. Chemotherapy services are typically highly complex and require direct physician supervision for any or all purposes of patient assessment, provision of consent, safety oversight and intra-service supervision of staff. Typically, such chemotherapy services require advanced practice training and competency for staff who provide these services; special considerations for preparation, dosage or disposal; and commonly, these services entail significant patient risk and frequent monitoring. Examples are frequent changes in the infusion rate, prolonged presence of nurse administering the solution for patient monitoring and infusion adjustments, and frequent conferring with the physician about these issues.

If performed to facilitate the infusion or injection, the following services are included and are not reported separately:

- a. Use of local anesthesia
- b. IV start
- c. Access to indwelling IV, subcutaneous catheter or port
- d. flush at conclusion of infusion
- e. standard tubing, syringes and supplies
- f. preparation of chemotherapy agent(s)

(For declotting a catheter or port, see 36550)

Report separate codes for each parenteral method of administration employed when chemotherapy is administered by different techniques. Medications (eg, antibiotics, steroidal agents, antiemetics, narcotics, analgesics) administered independently or sequentially as supportive management of chemotherapy administration, should be separately reported using 90760, 90761, 90765, 90766, 90767, 90768, 90772, 90773, 90774, 90775, 90779 as appropriate.

Report both the specific service as well as code(s) for the specific substance(s) or drug(s) provided.

When administering multiple infusions, injections or combinations, only one “initial” service code should be reported, unless protocol requires that two separate IV sites must be utilized. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported (e.g. the first IV push given subsequent to an initial one-hour infusion is reported using a subsequent IV push code).

If a significant separately identifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported utilizing modifier 25 in addition to 96400-96401-96549. For same day E/M service, a different diagnosis is not required.

~~Either may occur independently on any date of service, or they may occur sequentially on the same day.~~

~~Preparation of chemotherapy agent(s) is included in the service for administration of the agent.~~

*Regional (isolation) chemotherapy perfusion should be reported using the codes for intra-arterial infusion (96420-96425). Placement of the intra-arterial catheter should be reported using the appropriate code from the **Cardiovascular Surgery** section. Placement of arterial and venous cannula(s) for extracorporeal circulation via a membrane oxygenator perfusion pump should be reported using code 36823. Code 36823 includes dose calculation and administration of the chemotherapy agent by injection into the perfusate. Do not report code(s) ~~96408~~96409-96425 in conjunction with code 36823.*

~~Report separate codes for each parenteral method of administration employed when chemotherapy is administered by different techniques. Medications (eg, antibiotics, steroidal agents, antiemetics, narcotics, analgesics, biological agents) administered independently or sequentially as supportive management of chemotherapy administration, should be separately reported using ~~90780-90788~~, as appropriate.~~

(For Home Infusion services, see 99601-99602)

## Injection and Intravenous Infusion Chemotherapy

- 96400            ~~Chemotherapy administration, subcutaneous or intramuscular with or without local anesthesia~~  
(Code 96400 has been deleted. To report, see 96401, 96402)
- 96401 (H11) Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic
- 96402 (H12)            hormonal anti-neoplastic
- ▲96405            Chemotherapy administration; intralesional, up to and including 7 lesions
- ▲96406            intralesional, more than 7 lesions
- ~~96408~~            ~~Chemotherapy administration, intravenous; push technique~~  
(96408 has been deleted. To report, use 96409)
- 96409 (H13)            intravenous, push technique, single or initial substance/drug
- ~~96410~~            ~~intravenous infusion technique; up to one hour~~  
(96410 has been deleted. To report, use 96413)
- +•96411 (H14)            intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)  
(Use 96411 in conjunction with code 96409)
- ~~•96412~~            ~~infusion technique, one to 8 hours, each additional hour (List separately in addition to code for primary procedure)~~  
(Use 96412 in conjunction with code 96410)  
(96412 has been deleted. To report, use 96415)
- ~~96414~~            ~~infusion technique, initiation of prolonged infusion (more than 8 hours), requiring use of a portable or implantable pump~~  
(For refilling and maintenance of a portable pump or an implantable infusion pump or reservoir for drug delivery, see 96520, 96530)  
(96414 has been deleted. To report, use 96416)

- 96413 (H15) Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug
- +●96415 (H16) each additional hour, one to eight (8) hours (List separately in addition to code for primary procedure)  
(Use 96415 in conjunction with 96413)  
(Report 96415 for infusion intervals of greater than thirty minutes beyond one hour increments)  
(Report 90761 to identify hydration, or 90767 to identify nonchemotherapy drug infusion, if provided as a secondary or subsequent service in association with 96413)
- 96416 (H17) initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump  
(For insertion of pump, use 36563)  
(For refilling and maintenance of a portable pump or an implantable infusion pump or reservoir for drug delivery, see 96521, 96522, 96523)
- +●96417 (H18) each additional sequential infusion (different substance/drug), up to one hour (List separately in addition to code for primary procedure)  
(Use 96417 in conjunction with code 96413; report only once per sequential infusion; report 96415 for additional hour(s) of sequential infusion)

### **Intra-Arterial Chemotherapy**

96420 (H19) *Chemotherapy administration, intra-arterial; push technique*

96422 (H20) *infusion technique, up to one hour*

▲+96423 (H21) *infusion technique, each additional hour, one to ~~eight~~ hours, ~~each additional hour~~ (List separately in addition to code for primary procedure)*

*(Use 96423 in conjunction with 96422)*

*(Report 96423 for infusion intervals of greater than thirty minutes beyond one hour increments)*

*(For regional chemotherapy perfusion via membrane oxygenator perfusion pump to an extremity, use 36823)*

96425 (H22) *infusion technique, initiation of prolonged infusion (more than eight hours), requiring the use of a portable or implantable pump*

*(For insertion of pump, use 36260)*

*(For refilling and maintenance of a portable pump or an implantable infusion pump or reservoir for drug delivery, see 96520, 96521, 96522, 96523 96530)*

### **Other Chemotherapy**

*(See 36555-36597 for related intravascular access services)*

96440 *Chemotherapy administration into pleural cavity, requiring and including thoracentesis*

96445 *Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis*

96450 (H23) *Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture*

*(For intravesical (bladder) chemotherapy administration, see 51720)*

*(For insertion of subarachnoid catheter and reservoir for infusion of drug, see 62350, 62351, 62360, 62361, 62362; for insertion of intraventricular catheter and reservoir, see 61210, 61215)*

~~96520~~ ~~Refilling and maintenance of portable pump~~  
(96520 has been deleted. To report, use 96521)

•96521 (H24) Refilling and maintenance of portable pump

•96522 (H26) Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)  
(For refilling and maintenance of an implantable infusion pump for spinal or brain drug infusion, use 95990)  
(For collection of blood specimen from a completely implantable venous access device, use 36540)

•96523 (H25) Irrigation of implanted venous access device for drug delivery systems  
(Do not report 96523 if an injection or infusion is provided on the same day)

~~96530~~ ~~Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)~~  
~~(For refilling and maintenance of an implantable infusion pump for spinal or brain drug infusion, use 95990)~~  
~~(For collection of blood specimen from a completely implantable venous access device, use 36540)~~  
(96530 has been deleted. To report, use 96522)

96542 (H27) *Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents*

~~96545~~ ~~Provision of chemotherapy agent~~  
(96545 has been deleted)

96549 *Unlisted chemotherapy procedure*

## FINAL RUC WORK RECOMMENDATIONS FOR DRUG ADMINISTRATION CODES

	Hydration				Therapeutic/Diagnostic				Chemotherapy			
	CPT	ID	RVU	Time*	CPT	ID	RVU	Time*	CPT	ID	RVU	Time*
Initial infusion, up to 1 hr	90760	H1	0.17	2/3/2	90765	H3	0.21	2/5/2	96413	H15	0.28	4/7/2
each addt'l hr	90761	H2	0.09	0/3/0	90766	H5	0.18	0/3/0	96415	H16	0.19	0/5/0
additional sequential infusion, up to 1 hr					90767	H4	0.19	1/5/0	96417	H18	0.21	2/6/0
concurrent infusion					90768	H6	0.17	1/3/0				
Injection, single/initial					90772	H7	0.17	2/3/2	96401	H11	0.21	4/3/2
									96402	H12	0.19	4/3/2
IV push					90774	H9	0.18	2/5/2	96409	H13	0.24	4/5/2
each addt'l push					90775	H10	0.10	1/3/0	96411	H14	0.20	3/4/0
<i>Other chemo:</i>												
Initiation of prolonged chemo									96416	H17	0.21	4/4/2
Portable pump refill/maintenance									96521	H24	0.21	4/4/2
Irrigation implanted venous access device									96523	H25	0.04	2/0/0
Implantable pump/reservoir refill/maint									96522	H26	0.21	4/4/2

\* Times: pre/intra/post

\*\* Physician time for these codes reflect the direct supervision and interactions with clinical staff, rather than face-to-face with the patient.

**Projected Utilization for Drug Administration Services October 2004**

Surveyed CPT Code	How was service previously reported	Specialty Breakdown	For previously reported code, %age performed by each specialty in 2002 (from Medicare claims)	# Times Performed in 2002 (from Medicare claims)	How often do physicians in your specialty perform this service?	Projected number of times code will be reported
<b>90760</b>	90780	ACRh	5.49%	128,569	Sometimes	1,000
<b>H1</b>		AGA	0.28%	6,557	Sometimes	984
		ASCO/ASH*	65.45%	1,532,757	Commonly	306,551
		IDSA	5.53%	129,506	Sometimes	6,475
		All other specialties	23.25%	544,486	Varies	108,897
		<b>TOTAL</b>	<b>100.00%</b>	<b>2,341,876</b>	<b>N/A</b>	<b>423,907</b>
<b>90761</b>	90781	ACRh	14.49%	195,356	Sometimes	1,000
<b>H2</b>		AGA	0.61%	8,224	Sometimes	1,234
		ASCO/ASH*	46.99%	633,524	Commonly	306,551
		IDSA	4.35%	58,647	Sometimes	8,797
		All other specialties	33.56%	452,459	Varies	90,492
		<b>TOTAL</b>	<b>100.00%</b>	<b>1,348,210</b>	<b>N/A</b>	<b>408,074</b>
<b>90765</b>	90780	ACRh	5.49%	128,569	Rarely	0
<b>H3</b>		AGA	0.28%	6,557	Rarely	328
		ASCO/ASH*	65.45%	1,532,757	Commonly	1,226,206
		IDSA	5.53%	129,506	Sometimes	116,555
		All other specialties	23.25.00%	544,486	Varies	530,295
		<b>TOTAL</b>	<b>100.00%</b>	<b>2,341,876</b>	<b>N/A</b>	<b>1,873,384</b>
<b>90767</b>	N/A	ASCO/ASH* (90781)	N/A	N/A	Sometimes	122,620
<b>H4</b>		IDSA (90781)	N/A	N/A	Sometimes	38,121
		All other specialties	N/A	N/A	Varies	29,273
		<b>TOTAL</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>190,014</b>
<b>90766</b>	90781	ACRh	14.49%	195,356	Rarely	0
<b>H5</b>		AGA	0.61%	8,224	Rarely	411
		ASCO/ASH*	46.99%	633,524	Commonly	506,819
		IDSA	4.35%	58,647	Sometimes	11,729
		All other specialties	33.56%	452,459	Varies	534,049
		<b>TOTAL</b>	<b>100.00%</b>	<b>1,348,210</b>	<b>N/A</b>	<b>1,052,597</b>
<b>90768</b>	N/A	ASCO/ASH*	N/A	N/A	Sometimes	2,000
<b>H6</b>		IDSA (90780)	N/A	N/A	Sometimes	6,475
		All other specialties	N/A	N/A	Varies	2,000
		<b>TOTAL</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>10,475</b>

\*For the purposes of projecting utilization, Medicare frequency data for medical oncology, hematology, and hematology/oncology were combined.

**Projected Utilization for Drug Administration Services October 2004**

Surveyed CPT Code	How was service previously reported	Specialty Breakdown	For previously reported code, %age performed by each specialty in 2002 (from Medicare claims)	# Times Performed in 2002 (from Medicare claims)	How often do physicians in your specialty perform this service?	Projected number of times code will be reported
90772	90782	ACR <sub>h</sub>	2.46%	63,738	Sometimes	63,738
H7		ASCO/ASH*	31.23%	809,165	Commonly	809,165
		All other specialties	66.31%	1,718,084	Varies	1,718,084
		<b>TOTAL</b>	<b>100.00%</b>	<b>2,590,988</b>	<b>N/A</b>	<b>2,590,987</b>
90774	90784	ACR <sub>h</sub>	1.32%	829	Sometimes	829
H9		ASCO/ASH*	52.35%	32,884	Sometimes	32,884
		All other specialties	46.33%	29,102	Varies	29,102
		<b>TOTAL</b>	<b>100.00%</b>	<b>62,815</b>	<b>N/A</b>	<b>62,815</b>
90775	N/A	ASCO/ASH*	N/A	N/A	Sometimes	49,326
H10		All other specialties	N/A	N/A	Varies	43,653
		<b>TOTAL</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>92,979</b>
96401	96400	ASCO/ASH*	17.35%	134,309	Sometimes	75,213
H11		All other specialties	82.65%	639,805	Varies	2,411
		<b>TOTAL</b>	<b>100.00%</b>	<b>774,114</b>	<b>N/A</b>	<b>77,624</b>
96402	96400	ASCO/ASH*	17.35%	134,309	Sometimes	59,096
H12		AUA	76.62%	593,126	Commonly	540,000
		All other specialties	6.03%	46,679	Varies	96,703
		<b>TOTAL</b>	<b>100.00%</b>	<b>774,114</b>	<b>N/A</b>	<b>695,799</b>
96409	96408	ASCO/ASH*	86.77%	550,288	Commonly	550,288
H13		All other specialties	13.23%	83,904	Varies	83,904
		<b>TOTAL</b>	<b>100.00%</b>	<b>634,192</b>	<b>N/A</b>	<b>634,192</b>
96411	N/A	ASCO/ASH*	N/A	N/A	Commonly	220,115
H14		All other specialties	N/A	N/A	Varies	33,562
		<b>TOTAL</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>253,677</b>

\*For the purposes of projecting utilization, Medicare frequency data for medical oncology, hematology, and hematology/oncology were combined.

Projected Utilization for Drug Administration Services October 2004						
Surveyed CPT Code	How was service previously reported	Specialty Breakdown	For previously reported code, %age performed by each specialty in 2002 (from Medicare claims)	# Times Performed in 2002 (from Medicare claims)	How often do physicians in your specialty perform this service?	Projected number of times code will be reported
96413	90780	ACR <sub>h</sub>	5.49%	128,569	Sometimes	127,569
H15		AGA	0.28%	6,557	Sometimes	5,246
		ASCO/ASH*	65.45%	1,532,757	N/A	see below
		All other specialties	28.78%	673,992	Varies	17,654
		<b>(Sub)Total minus ASCO/ASH</b>	<b>34.55%</b>	<b>809,118</b>	<b>N/A</b>	<b>150,469</b>
	96410	ASCO/ASH*	85.81%	1,515,887	Commonly	1,515,887
		ACR <sub>h</sub>	0.01%	177	N/A	see above
		AGA	0.02%	353	N/A	see above
		All other specialties minus ACR <sub>h</sub> and AGA	14.16%	250,262	Varies	250,262
		<b>(Sub)Total minus ACR<sub>h</sub> and AGA</b>	<b>99.97%</b>	<b>1,766,856</b>	<b>N/A</b>	<b>1,766,856</b>
		<b>TOTAL</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>1,917,325</b>
96415	90781	ACR <sub>h</sub>	14.49%	195,356	Sometimes	194,356
H16		AGA	0.61%	8,224	Sometimes	6,579
		ASCO/ASH*	46.99%	633,524	N/A	see below
		All other specialties	37.91%	511,106	Varies	13,289
		<b>(Sub)Total minus ASCO/ASH</b>	<b>53.01%</b>	<b>714,686</b>	<b>N/A</b>	<b>214,224</b>
	96412	ASCO/ASH*	84.95%	1,325,833	Commonly	662,917
		ACR <sub>h</sub>	0.01%	156	N/A	see above
		AGA	0.04%	624	N/A	see above
		All other specialties	15.00%	234,117	Varies	117,059
		<b>(Sub)Total minus ACR<sub>h</sub> and AGA</b>	<b>99.95%</b>	<b>1,559,999</b>	<b>N/A</b>	<b>779,976</b>
		<b>TOTAL</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>994,200</b>
96416	96414	ASCO/ASH*	86.17%	23,074	Sometimes	23,074
H17		All other specialties	13.83%	3,703	Varies	3,703
		<b>TOTAL</b>	<b>100.00%</b>	<b>26,777</b>	<b>N/A</b>	<b>26,777</b>
96417	964X2	ASCO/ASH*	N/A	N/A	Commonly	1,061,121
H18		All other specialties	N/A	N/A	Varies	125,396
		<b>TOTAL</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>1,186,517</b>
96521	96520	ASCO/ASH*	71.99%	24,123	Sometimes	24,123
H24		All other specialties	28.01%	9,386	Varies	9,386
		<b>TOTAL</b>	<b>100.00%</b>	<b>33,509</b>	<b>N/A</b>	<b>33,509</b>
96523	96530	ASCO/ASH*	44.12%	80,546	Sometimes	64,437
H25		All other specialties	55.88%	102,016	Varies	81,613
		<b>TOTAL</b>	<b>100.00%</b>	<b>182,562</b>	<b>N/A</b>	<b>146,050</b>

\*For the purposes of projecting utilization, Medicare frequency data for medical oncology, hematology, and hematology/oncology were combined.

Projected Utilization for Drug Administration Services October 2004						
Surveyed CPT Code	How was service previously reported	Specialty Breakdown	For previously reported code, %age performed by each specialty in 2002 (from Medicare claims)	# Times Performed in 2002 (from Medicare claims)	How often do physicians in your specialty perform this service?	Projected number of times code will be reported
96522	96530	ASCO/ASH*	44.12%	80,546	Sometimes	16,109
H26		All other specialties	55.88%	102,016	Varies	20,403
		<b>TOTAL</b>	<b>100.00%</b>	<b>182,562</b>	<b>N/A</b>	<b>36,512</b>

\*For the purposes of projecting utilization, Medicare frequency data for medical oncology, hematology, and hematology/oncology were combined.

## Notes on Assumptions

Specialty	Codes	Assumption
AGA	90780/90781	80% of 90780/90781 will move to H15/H16 15% of 90780/90781 will move to hydration codes H1/H2. 5% of 90780/90781 will move to tx/dx infusion codes H3/H5. 0% will go to additional sequential or concurrent tx/dx infusion codes.
ACRrh	90780/90781	Vast majority of what is currently being coded as 90780/90781 will move to H15/H16 Leaving 1000 for hydration codes H1/H2.
IDSA	90780/90781	5% will move from 90780 to H1 (first hour, hydration). 5% will move from 90780 to H6 (concurrent infusion). 90% will move from 90780 to H3 (tx/dx infusion). 15% of 90781 will move to H2 (additional hour, hydration). 20% of 90781 will shift to H5 (each additional hour, tx/dx infusion). 65% of 90781 will move to H4 (additional sequential tx/dx infusion).
ASCO/ASH	90780/90781	20% of 90780 will shift to H1 (first hour hydration). There will be a 1:1 ratio between frequency of H1 and H2 (additional hour hydration) because of assumption that average hydration is 2 hours. 80% of 90780 will shift to H3 (first hour tx/dx infusion). Approx. 8% of 90781 will shift to H4 (each additional sequential tx/dx infusion). 80% of 90781 will shift to H5 (each additional hour tx/dx infusion).
ASCO/ASH	H7	Assume no change.
ASCO/ASH	H9	Assume no change.
ASCO/ASH	H10	Assume 150% of H19.
ASCO/ASH	96400	Assume 56% of 96400 shifts to H11. Assume 46% of 96400 shifts to H12.
ASCO/ASH	H13	Assume no change.
ASCO/ASH	H14	Assume 1.4 drugs are given by push on average. Assume 40% of H13
ASCO/ASH	H15	Assume no change.
ASCO/ASH	H16	Assume 50% of previous utilization.
ASCO/ASH	H18	Assume 1.7 drugs are given by infusion on average. Assume 70% of H15.
ASCO/ASH	H24	Assume no change.
ASCO/ASH	H17	Assume no change.
ASCO/ASH	H26	Assume 80% of utilization will shift to H25 and 20% will be retained in H26.
All other specialties	90780/90781	Assume 20% of 90780/90781 will shift to H1 and H2 (hydration).
All other specialties	H6	Assumed concurrent infusions to be infrequently performed by all specialties.

CPT Code: \_\_\_\_\_

Specialty Society('s) \_\_\_\_\_

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
In Office Direct Inputs**

CPT Family: Hydration and Therapeutic and Diagnostic Infusions of Non-chemotherapy per attached spreadsheet (90760-90775)

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

Geographic Practice Setting %: Rural \_\_\_\_\_ Suburban \_\_\_\_\_ Urban \_\_\_\_\_

Type of Practice %: \_\_\_\_\_ Solo Practice  
\_\_\_\_\_ Single Specialty Group  
\_\_\_\_\_ Multispecialty Group  
\_\_\_\_\_ Medical School Faculty Practice Plan

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

**ASCO, ASH, ACRh, AGA, IDSA, and AUA convened to review practice expense inputs for the 90760-90775 family of codes. The groups used as a basis for discussion the March 2002 PEAC approved inputs for this family. The group considered input from two oncology certified nurses and considered recommendations outlined by the Community Oncology Alliance task force.**

**(Background on the March 2002 PEAC recommendations: ASCO and ASH first convened a panel of nurses, who perform these procedures on a daily basis, to determine the inputs for clinical staff time and procedure-specific medical supplies and equipment. The data were then carefully scrutinized by a consensus panel of experts who approved the inputs. Both of these panels included a combination of rural, suburban, and urban practices; solo, single and multi-specialty groups, as well as medical school faculty were represented. The AUA and the Endocrine Society reviewed and accepted the inputs that were recommended in 2002.)**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: **The RN/OCN escorts patient to chemo chair and completes a pre-chemotherapy check to insure that patient is able to receive treatment. The nurse prepares the drug(s) and educates patient on adverse effects.**

Intra-Service Clinical Labor Activities: **The nurse administers drug to the patient and monitors response to treatment throughout. Nurse consults with supervising physician during course of treatment.**

Post-Service Clinical Labor Activities: **The nurse continues to monitor the patient after treatment is completed. S/he documents the treatment in the medical record and reviews instructions with patient. The nurse makes follow up phone calls to the patient and others with whom care is being coordinated.**

	A	B	C		D		E		F		G		H		K	L
1			2004 Recommendation		2004 Recommendation		2004 Recommendation		2004 Recommendation		2004 Recommendation		2004 Recommendation			
2		Tracking #	H1		H2		H3		H4		H3		H4			
3		CPT code	90760		90761		90765		90767		90765		90767			
4		HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Intravenous infusion, hydration; initial, up to one hour		Intravenous infusion, hydration; each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure) (Use 90780X2 in conjunction with code 90780X1)		Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour		Intravenous infusion, for therapy/diagnosis, (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for primary procedure)		Intravenous infusion, for therapy/diagnosis, (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for primary procedure)		Intravenous infusion, for therapy/diagnosis, (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for primary procedure)			
5	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office		
6	GLOBAL PERIOD		xxx		zzz		XXX		ZZZ		ZZZ		ZZZ			
7	TOTAL CLINICAL LABOR TIME		40		10		50		22		22		22			
8	Staff Type L056A=RN/OCN		L056A		L056A		L056A		L056A		L056A		L056A			
9	Total Pre-time		3		0		6		0		0		0			
10	Total Intra-time		34		10		41		22		22		22			
11	Total Post-time		3		0		3		0		0		0			
12	PRE-SERVICE															
13	Start: Following visit when decision for surgery or procedure made															
14	Complete pre-service diagnostic & referral forms		0		0		3		0		0		0			
15	Coordinate pre-surgery services		3		0		3		0		0		0			
16	Office visit before surgery/procedure: Review test and exam results		0		0		0		0		0		0			
17	Provide pre-service education/obtain consent		0		0		0		0		0		0			
18	Follow-up phone calls & prescriptions		0		0		0		0		0		0			
19	Other Clinical Activity (please specify)		0		0		0		0		0		0			
20	End:When patient enters office for surgery/procedure															
21	SERVICE PERIOD															
22	Start: When patient enters office for surgery/procedure															
23	Pre-service services															
24	Review charts - obtain medical history		2		0		2		0		0		0			
25	Greet patient and provide gowning		2		0		2		0		0		0			
26	Obtain vital signs		3		3		3		3		3		3			
27	Provide pre-service education/obtain consent		3		0		3		0		0		0			
28	Prepare room, equipment, supplies		2		0		2		0		0		0			
29	Prepare and position patient and mix drug		2		0		2		0		0		0			
30	Mix drug		0		0		7		7		7		7			
31	Sedate/apply anesthesia		0		0		0		0		0		0			
32	Intra-service															
33	Perform procedure		10		7		12		9		9		9			
34	Post-Service															
35	Monitor pt. following service/check tubes, monitors, drains		2		0		0		0		0		0			
36	Clean room/equipment by physician staff		3		0		3		0		0		0			
37	Complete medical record documentation		2		0		2		3		3		3			
38	Review/read X-ray, lab, and pathology reports		0		0		0		0		0		0			
39	Post procedure education / Check dressings & wound/ home care instructions /coordinate office visits /prescriptions		3		0		3		0		0		0			
40	End: Patient leaves office															
41	POST-SERVICE PERIOD															
42	Start: Patient leaves office															
43	Conduct phone calls/call in prescriptions		3		0		3		0		0		0			
44	Office visits: Greet patient, escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results; assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling, clean room/equip, check supplies; coordinate home or outpatient care															
45	List Number and Level of Office Visits															
46	99211 16 minutes															
47	99212 27 minutes															
48	99213 36 minutes															
49	99214 53 minutes															
50	99215 63 minutes															
51	Other															
52	Total Office Visit Time															
53	Conduct phone calls between office visits															
54	Other Activity (please specify)															
55	End: with last office visit before end of global period															

	A	B	C	D	E	F	G	H	K	L
3		CPT code	90760		90761		90765		90767	
4		HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Intravenous infusion, hydration; initial, up to one hour		Intravenous infusion, hydration; each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure) (Use 90780X2 in conjunction with code 90780X1)		Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour		Intravenous infusion, for therapy/diagnosis, (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for primary procedure)	
5	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
74	<b>MEDICAL SUPPLIES</b>									
75	drape, non-sterile, sheet 40in x 60in	SB006								
76	gown, patient	SB026								
77	paper, exam table	SB036	7				7			
78	gloves, non-sterile	SB022	2				2		1	
79	gloves, sterile	SB024					0		0	
80	gloves, non-sterile, nitrile	SB023								
81	gown, staff, impervious	SB027								
82	cover, thermometer probe	SB004	1				1			
83	swab-pad, alcohol	SJ053	2				2			
84	povidone swabsticks (3 pack uou)	SJ043								
85	bandage, strip 0.75in x 3in	SG021	1				1			
86	needle, 19-25g, butterfly	SC030								
87	infusion pump cassette-reservoir	SC013								
88	iv infusion set	SC018	1				1			
89	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	1				1			
90	synnge 10-12ml	SC051	1				1			
91	syringe 1ml	SC052								
92	synnge 20ml	SC053								
93	syringe 50-60ml	SC056								
94	water, sterile inj	SH075	0				0			
95	angiocatheter 14g-24g	SC001	1				1			
96	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068								
97	gauze, non-sterile 2in x 2in	SG050	2				2			
98	dressing, 4in x 4.75in (Tegaderm)	SG037								
99	steri-stnp (6 stnp uou)	SG074								
100	iv tubing (extension)	SC019								
101	battery, 9 volt	SK010								
102	syringe 3ml	SC055								
103	albumin saline	SH004								
	op cock, 3-way	SC041								
	syringe 30 ml	SC054								
106	blood collection bag	SC004								
107	eye shield, non-fox	SG049	0				0			
108	sodium chloride, 99.0% min.	SL126								
109	bandage, elastic, self-adherent wrap 1in (Coban)	SG014	1				1			
110	<b>Equipment</b>									
111	biohazard hood (\$7612.00)						0		0	
112	chemo couch	E91004								
113	infusion pump	E91001	1				1		1	
114	exam table	E11001	1				1		1	

A	B	O	P	Q	R
1		2004 Recommendation		2004 Recommendation	
2		H5		H6	
3	Tracking # CPT code	90766		90768	
4	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Intravenous infusion, for therapy/diagnosis, (specify substance or drug); each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)		Intravenous infusion, for therapy/diagnosis, (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure) (report only once per substance/drug, regardless of duration)	
5	LOCATION	In Office	Out Office	In Office	Out Office
6	GLOBAL PERIOD	ZZZ		ZZZ	
7	TOTAL CLINICAL LABOR TIME	12		11	
8	Staff Type L056A=RN/OCN	L056A		L056A	
9	Total Pre-time	0		0	
10	Total Intra-time	12		11	
11	Total Post-time	0		0	
12	<b>PRE-SERVICE</b>				
13	Start: Following visit when decision for surgery or procedure made				
14	Complete pre-service diagnostic & referral forms	0		0	
15	Coordinate pre-surgery services	0		0	
16	Office visit before surgery/procedure: Review test and exam results	0		0	
17	Provide pre-service education/obtain consent	0		0	
18	Follow-up phone calls & prescriptions	0		0	
19	Other Clinical Activity (please specify)	0		0	
20	End:When patient enters office for surgery/procedure				
21	<b>SERVICE PERIOD</b>				
22	Start: When patient enters office for surgery/procedure				
23	Pre-service services				
24	Review charts - obtain medical history	0		0	
25	Greet patient and provide gowning	0		0	
26	Obtain vital signs	3		0	
27	Provide pre-service education/obtain consent	0		0	
28	Prepare room, equipment, supplies	0		0	
29	Prepare and position patient and mix drug	0		6	
30	Mix drug	0		0	
31	Sedate/apply anesthesia	0		0	
32	Intra-service				
33	Perform procedure	9		3	
34	Post-Service				
35	Monitor pt. following service/check tubes, monitors, drains	0		2	
36	Clean room/equipment by physician staff	0		0	
37	Complete medical record documentation	0		0	
38	Review/read X-ray, lab, and pathology reports	0		0	
39	Post procedure education / Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	0		0	
40	End: Patient leaves office				
41	<b>POST-SERVICE Period</b>				
42	Start: Patient leaves office				
43	Conduct phone calls/call in prescriptions	0		0	
44	Office visits: Greet patient, escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results; assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip. check supplies; coordinate home or outpatient care				
45	List Number and Level of Office Visits				
46	99211 16 minutes				
47	99212 27 minutes				
48	99213 36 minutes				
49	99214 53 minutes				
50	99215 63 minutes				
51	Other				
52	Total Office Visit Time				
53	Conduct phone calls between office visits				
54	Other Activity (please specify)				
55	End: with last office visit before end of global period				

	A	B	O	P	Q	R
3		CPT code	90766		90768	
4		HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Intravenous infusion, for therapy/diagnosis, (specify substance or drug); each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)		Intravenous infusion, for therapy/diagnosis, (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure) (report only once per substance/drug, regardless of duration)	
5	LOCATION		In Office	Out Office	In Office	Out Office
74	<b>MEDICAL SUPPLIES</b>					
75	drape, non-sterile, sheet 40in x 60in	SB006				
76	gown, patient	SB026				
77	paper, exam table	SB036				
78	gloves, non-sterile	SB022	1			
79	gloves, sterile	SB024				
80	gloves, non-sterile, nitrile	SB023				
81	gown, staff, impervious	SB027				
82	cover, thermometer probe	SB004				
83	swab-pad, alcohol	SJ053				
84	povidone swabsticks (3 pack uou)	SJ043				
85	bandage, strip 0.75in x 3in	SG021				
86	needle, 19-25g, butterfly	SC030				
87	infusion pump cassette-reservoir	SC013				
88	iv infusion set	SC018				
89	syringe w-needle, OSHA compliant (SafetyGlide)	SC058				
90	synnge 10-12ml	SC051				
91	syringe 1ml	SC052				
92	syringe 20ml	SC053				
93	syringe 50-60ml	SC056				
94	water, sterile inj	SH075				
95	angiocatheter 14g-24g	SC001				
96	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068				
97	gauze, non-sterile 2in x 2in	SG050				
98	dressing, 4in x 4.75in (Tegaderm)	SG037				
99	steri-strip (6 strip uou)	SG074				
100	iv tubing (extension)	SC019				
101	battery, 9 volt	SK010				
102	syringe 3ml	SC055				
	albumin saline	SH004				
	op cock, 3-way	SC041				
	syringe 30 ml	SC054				
106	blood collection bag	SC004				
107	eye shield, non-fox	SG049				
108	sodium chloride, 99.0% min.	SL126				
109	bandage, elastic, self-adherent wrap 1in (Coban)	SG014				
110	<b>Equipment</b>					
111	biohazard hood (\$7612.00)				0	
112	chemo couch	E91004				
113	infusion pump	E91001	1			
114	exam table	E11001	1			

	A	B	S	T	W	X	AA	AB
1			2004 Recommendation		2004 Recommendation		2004 Recommendation	
2		Tracking #	H7		H9		H10	
3		CPT code	90772		90774		90775	
4		HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Therapeutic, or diagnostic injection (specify material injected substance or drug); subcutaneous or intramuscular		Therapeutic, or diagnostic injection (specify material injected substance or drug); intravenous push, single or initial substance/drug		Therapeutic, or diagnostic injection (specify material injected substance or drug); each additional sequential intravenous push (List separately in addition to code for primary procedure)	
5	LOCATION		In Office	Out Office	In Office		In Office	Out Office
6	GLOBAL PERIOD		XXX		XXX		ZZZ	
7	TOTAL CLINICAL LABOR TIME		32		41		16	
8	Staff Type L056A=RN/OCN		L056A		L056A		L056A	
9	Total Pre-time		3		6		0	
10	Total Intra-time		26		32		16	
11	Total Post-time		3		3		0	
12	<b>PRE-SERVICE</b>							
13	Start: Following visit when decision for surgery or procedure made							
14	Complete pre-service diagnostic & referral forms		3		3		0	
15	Coordinate pre-surgery services		0		3		0	
16	Office visit before surgery/procedure: Review test and exam results		0		0		0	
17	Provide pre-service education/obtain consent		0		0		0	
18	Follow-up phone calls & prescriptions		0		0		0	
19	Other Clinical Activity (please specify)		0		0		0	
20	End:When patient enters office for surgery/procedure							
21	<b>SERVICE PERIOD</b>							
22	Start: When patient enters office for surgery/procedure							
23	Pre-service services							
24	Review charts - obtain medical history		2		2		0	
25	Greet patient and provide gowning		2		2		0	
26	Obtain vital signs		0		3		3	
27	Provide pre-service education/obtain consent		3		3		0	
28	Prepare room, equipment, supplies		2		2		0	
29	Prepare and position patient and mix drug		2		2		0	
30	Mix drug		6		5		5	
31	Sedate/apply anesthesia		0		0		0	
32	Intra-service							
33	Perform procedure		1		8		6	
34	Post-Service							
35	Monitor pt. following service/check tubes, monitors, drains		0		3		2	
36	Clean room/equipment by physician staff		3		0		0	
37	Complete medical record documentation		2		2		0	
38	Review/read X-ray, lab, and pathology reports		0		0		0	
39	Post procedure education / Check dressings & wound/ home care instructions /coordinate office visits /prescriptions		3		0		0	
40	End: Patient leaves office							
41	<b>POST-SERVICE PERIOD</b>							
42	Start: Patient leaves office							
43	Conduct phone calls/call in prescriptions		3		3		0	
44	Office visits: Greet patient, escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results; assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care							
45	List Number and Level of Office Visits							
46	99211 16 minutes							
47	99212 27 minutes							
48	99213 36 minutes							
49	99214 53 minutes							
50	99215 63 minutes							
51	Other							
52	Total Office Visit Time							0
53	Conduct phone calls between office visits							
54	Other Activity (please specify)							
55	End: with last office visit before end of global period							

	A	B	S	T	W	X	AA	AB
3		CPT code	90772		90774		90775	
4		HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Therapeutic, or diagnostic injection (specify material injected substance or drug); subcutaneous or intramuscular		Therapeutic, or diagnostic injection (specify material injected substance or drug); intravenous push, single or initial substance/drug		Therapeutic, or diagnostic injection (specify material injected substance or drug); each additional sequential intravenous push (List separately in addition to code for primary procedure)	
5	LOCATION		In Office	Out Office	In Office		In Office	Out Office
74	<b>MEDICAL SUPPLIES</b>							
75	drape, non-sterile, sheet 40in x 60in	SB006						
76	gown, patient	SB026						
77	paper, exam table	SB036						
78	gloves, non-sterile	SB022	1		1		1	
79	gloves, sterile	SB024						
80	gloves, non-sterile, nitrile	SB023						
81	gown, staff, impervious	SB027						
82	cover, thermometer probe	SB004	1		1			
83	swab-pad, alcohol	SJ053	1		1		2	
84	povidone swabsticks (3 pack uou)	SJ043						
85	bandage, strip 0.75in x 3in	SG021	1		1			
86	needle, 19-25g, butterfly	SC030						
87	infusion pump cassette-reservoir	SC013						
88	iv infusion set	SC018						
89	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	1		1		1	
90	syringe 10-12ml	SC051			1		1	
91	syringe 1ml	SC052						
92	syringe 20ml	SC053						
93	syringe 50-60ml	SC056						
94	water, sterile inj	SH075						
95	angiocatheter 14g-24g	SC001			1			
96	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068						
97	gauze, non-sterile 2in x 2in	SG050			2			
98	dressing, 4in x 4.75in (Tegaderm)	SG037						
99	steri-strip (6 strip uou)	SG074						
100	iv tubing (extension)	SC019						
101	battery, 9 volt	SK010						
102	syringe 3ml	SC055	1		1		1	
	albumin saline	SH004						
	stop cock, 3-way	SC041						
103	syringe 30 ml	SC054						
106	blood collection bag	SC004						
107	eye shield, non-fox	SG049	0		0			
108	sodium chloride, 99.0% min.	SL126						
109	bandage, elastic, self-adherent wrap 1in (Coban)	SG014			1			
110	<b>Equipment</b>							
111	biohazard hood (\$7612.00)		0					
112	chemo couch	E91004						
113	infusion pump	E91001						
114	exam table	E11001	13		1			

CPT Code: \_\_\_\_\_  
Specialty Society('s) \_\_\_\_\_

**AMA/Specialty Society Update Process  
PEAC Summary of Recommendation  
XXX Global Period  
In Office Direct Inputs**

CPT Family: **Therapeutic and Diagnostic Infusions and Injections of Chemotherapy per attached spreadsheet (96401 – 96522)**

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

Geographic Practice Setting %: Rural \_\_\_\_\_    Suburban \_\_\_\_\_    Urban \_\_\_\_\_

Type of Practice %:    \_\_\_\_\_ Solo Practice  
                                  \_\_\_\_\_ Single Specialty Group  
                                  \_\_\_\_\_ Multispecialty Group  
                                  \_\_\_\_\_ Medical School Faculty Practice Plan

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

**ASCO, ASH, ACRh, AGA, IDSA, and AUA convened to review practice expense inputs for the 96401-96522 family of codes. The groups used as a basis for discussion the March 2002 PEAC approved inputs for this family. The group considered input from two oncology certified nurses and considered recommendations outlined by the Community Oncology Alliance task force.**

**(Background on the March 2002 PEAC recommendations: ASCO and ASH first convened a panel of nurses, who perform these procedures on a daily basis, to determine the inputs for clinical staff time and procedure-specific medical supplies and equipment. The data were then carefully scrutinized by a consensus panel of experts who approved the inputs. Both of these panels included a combination of rural, suburban, and urban practices; solo, single and multi-specialty groups, as well as medical school faculty were represented. The AUA and the Endocrine Society reviewed and accepted the inputs that were recommended in 2002.)**

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities: **The RN/OCN escorts patient to chemo chair and completes pre-chemotherapy check to insure that patient is able to receive treatment. The nurse prepares the drug(s) and educates patient on adverse effects.**

Intra-Service Clinical Labor Activities: **The nurse administers drug to the patient and monitors for toxicity throughout. Nurse consults with supervising physician during course of treatment.**

Post-Service Clinical Labor Activities: **The nurse continues to monitor the patient after treatment is completed. S/he documents the treatment in the medical record and reviews instructions with patient. The nurse makes follow up phone calls to the patient and others with whom care is being coordinated.**

	A	B	C		D		E		F		I		J		M	N
1			2004 Recommendation		2004 Recommendation		2004 Recommendation		2004 Recommendation		2004 Recommendation		2004 Recommendation			
2		Tracking #	H11		H12		H13		H14		H13		H14			
3		CPT code	96401		96402		96409		96411		96409		96411			
4		HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic		Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic		Chemotherapy administration, intravenous, push technique, single or initial substance/drug		Chemotherapy administration, intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure) (Use 964X1 in conjunction with code 96408)							
5	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office		
6	GLOBAL PERIOD		XXX		XXX	XXX			XXX		ZZZ					
7	TOTAL CLINICAL LABOR TIME		59		45	XXX			85		46					
8	STAFF TYPE L051A=RN, L056A=RN/OCN		L056A		L051A				L056A		L056A					
9	Total Pre-time		6		6				6		0					
10	Total Intra-time		50		36				73		46					
11	Total Post-time		3		3				6		0					
12	PRE-SERVICE															
	Start: Following visit when decision for surgery or procedure made															
14	Complete pre-service diagnostic & referral forms		3		3				3		0					
15	Coordinate pre-surgery services		3		3				3		0					
16	Office visit before surgery/procedure: Review test and exam results		0		0				0		0					
17	Provide pre-service education/obtain consent		0		0				0		0					
18	Follow-up phone calls & prescriptions		0		0				0		0					
19	Other Clinical Activity (please specify)		0		0				0		0					
20	End:When patient enters office for surgery/procedure		0		0				0		0					
21	SERVICE PERIOD															
	Start: When patient enters office for surgery/procedure															
22	Pre-service services	RN/OCN														
24	treatment & obtain chemotherapy-related medical hx	L056A	4		2				4		0					
25	Greet patient and provide gowning		2		2				2		0					
26	Obtain vital signs		3		3				3		3					
27	(initial education of 1 hr amortized over average of 6 cycles)		5		5				8		2					
28	Prepare room, equipment, supplies		2		2				2		0					
29	Prepare and position patient and mix chemotherapy		2		2				2		0					
30	ix chemotherapy		13		8				19		19					
31	sedate/apply anesthesia		0		0				0		0					
48	Intra-service															
49	Perform procedure or Assist physician in performing procedure		1		1				15		15					
62	Post-Service															
63	Monitor pt. following service/check tubes, monitors, drains		5		0				5		5					
64	Clean room/equipment by physician staff		3		3				3		0					
65	Complete medical record documentation, diagnostic forms, lab & X-ray requisitions		5		3				5		2					
66	Review/read X-ray, lab, and pathology reports		0		0				0		0					
67	Post procedure education /conditions for which patient should call office (side effects, complications) home care instructions /coordinate office visits /prescriptions		5		5				5		0					
68	End: Patient leaves office															
69	POST-SERVICE Period															
70	Start: Patient leaves office															
71	Conduct phone calls/call in prescriptions		3		3				6							
72	Office visits: Greet patient, escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results; assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care															
73	List Number and Level of Office Visits															
74	99211 16 minutes															
75	99212 27 minutes															
76	99213 36 minutes															
77	99214 53 minutes															
78	99215 63 minutes															
79	Other															
80	Total Office Visit Time															
81	Conduct phone calls between office visits															
82	Other Activity (please specify)															
	End: with last office visit before end of global period															
	MEDICAL SUPPLIES															
85	drape, non-sterile, sheet 40in x 60in	SB006							0							
86	gown, patient	SB026														
87	paper, exam table	SB036	7		7											
88	gloves, non-sterile	SB022			1				1		1					
89	gloves, sterile	SB024														
90	gloves, non-sterile, nitrile	SB023	1						0		0					
91	gown, staff, impervious	SB027	1						1		0					
92	cover, thermometer probe	SB004	1		1											

	A	B	C	D	E	F	I	J	M	N
1			2004 Recommendation		2004 Recommendation		2004 Recommendation		2004 Recommendation	
2		Tracking #	H11		H12		H13		H14	
3		CPT code	96401		96402		96409		96411	
4		HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic		Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic		Chemotherapy administration; Intravenous, push technique, single or Initial substance/drug		Chemotherapy administration; Intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure) (Use 964X1 in conjunction with code 96408)	
5	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
93	swab-pad, alcohol	SJ053	1		1		2		2	
94	povidone swabsticks (3 pack uou)	SJ043								
95	bandage, strp 0.75in x 3in	SG021	1		1		1			
96	needle, 19-25g, butterfly	SC030					1		1	
97	infusion pump cassette-reservoir	SC013								
98	iv infusion set	SC018					1		1	
99	synnge w-needle, OSHA compliant (SafetyGlide)	SC058	1				3		1	
100	synnge 10-12ml	SC051	1				1		1	
101	synnge 1ml	SC052	1				1		1	
102	synnge 20ml	SC053					1			
103	synnge 50-60ml	SC056					1			
104	water, sterile inj	SH075	1				2		1	
105	angiocatheter 14g-24g	SC001								
106	sodium chloride 0.9% inj bactenostatic (30ml uou)	SH068								
107	gauze, non-sterile 2in x 2in	SG050	2		2					
108	dressing, 4in x 4.75in (Tegaderm)	SG037								
109	sten-strip (6 strp uou)	SG074								
110	iv tubing (extension)	SC019								
111	battery, 9 volt	SK010								
112	synnge 3ml	SC055								
113	albumin saline	SH004								
114	stop cock, 3-way	SC041								
115	synnge 30 ml	SC054								
116	blood collection bag	SC004								
117	eye shield, non-fox	SG049					0			
118	sodium chloride, 99.0% min.	SL126								
119	bandage, elastic, self-adherent wrap 1in (Coban)	SG014								
120	pack, minimum multi-specialty visit	SA048					0			
	eedle, Huber point	SC039								
	ynnge with needle, OSHA compliant	SC058			0					
123	tray, lumbar puncture	SA065								
124	graham crackers, 1 packet	SK040								
125	juice, apple, 1 oz	SK042								
126	cup, drinking	SK018								
127	hepapp 1,000 units-ml inj	SH039					1		1	
128	<b>Equipment</b>									
129	biohazard hood (\$7,612.00)		15				15		15	
130	chemo couch	E91004					71		1	
131	infusion pump	E91001								
132	exam table	E1001	46		1					

	A	B	O	P	S	T	W	X	AA	AB
1			2004 Recommendation		2004 Recommendation		2004 Recommendation		2004 Recommendation	
2		Tracking #	H15		H16		H17		H18	
3		CPT code	96413		96415		96416		96417	
4		HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug		Chemotherapy administration, intravenous infusion technique; each additional hour, one to eight (8) hours (List separately in addition to code for primary procedure)(Use 96412 in conjunction with 96410)		Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump		Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to one hour (List separately in addition to code for primary procedure)	
5	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
6	GLOBAL PERIOD		XXX		ZZZ		XXX		ZZZ	
7	TOTAL CLINICAL LABOR TIME		98		20		108		49	
8	STAFF TYPE L051A=RN, L056A=RN/OCN		L056A		L056A		L056A		L056A	
9	Total Pre-time		6		0		6		0	
10	Total Intra-time		86		20		96		49	
11	Total Post-time		6		0		6		0	
12	PRE-SERVICE									
13	Start: Following visit when decision for surgery or procedure made									
14	Complete pre-service diagnostic & referral forms		3		0		3		0	
15	Coordinate pre-surgery services		3		0		3		0	
16	Office visit before surgery/procedure: Review test and exam results		0		0		0		0	
17	Provide pre-service education/obtain consent		0		0		0		0	
18	Follow-up phone calls & prescriptions		0		0		0		0	
19	Other Clinical Activity (please specify)		0		0		0		0	
20	End:When patient enters office for surgery/procedure		0		0		0		0	
21	SERVICE PERIOD									
22	Start: When patient enters office for surgery/procedure	RN/OCN								
23	Pre-service services									
24	treatment & obtain chemotherapy-related medical hx	L056A	4		0		4		0	
25	Greet patient and provide gowning		2		0		2		0	
26	Obtain vital signs		3		3		3		3	
27	(initial education of 1 hr amortized over average of 6 cycles)		8		0		8		0	
28	Prepare room, equipment, supplies		2		0		2		0	
29	Prepare and position patient and mix chemotherapy		2		0		2		0	
30	ix chemotherapy		20		0		28		18	
31	sedate/apply anesthesia		0		0		0		0	
32	Intra-service									
33	Perform procedure or Assist physician in performing procedure		27		17		19		23	
34	Post-Service									
35	Monitor pt. following service/check tubes, monitors, drains		5		0		5		5	
36	Clean room/equipment by physician staff		3		0		3		0	
37	Complete medical record documentation, diagnostic forms, lab & X-ray requisitions		5		0		5		0	
38	Review/read X-ray, lab, and pathology reports		0		0		0		0	
39	Post procedure education /conditions for which patient should call office (side effects, complications) home care instructions /coordinate office visits /prescriptions		5		0		15		0	
40	End: Patient leaves office									
41	POST-SERVICE Period									
42	Start: Patient leaves office									
43	Conduct phone calls/call in prescriptions		6				6			
44	Office visits: Greet patient, escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results, assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care									
45	List Number and Level of Office Visits									
46	99211 16 minutes									
47	99212 27 minutes									
48	99213 36 minutes									
49	99214 53 minutes									
50	99215 63 minutes									
51	Other									
52	Total Office Visit Time									
53	Conduct phone calls between office visits									
54	Other Activity (please specify)									
55	End: with last office visit before end of global period									
56	MEDICAL SUPPLIES									
57	drape, non-sterile, sheet 40in x 60in	SB006	0				1			
58	gown, patient	SB026								
59	paper, exam table	SB036								
60	gloves, non-sterile	SB022	1						1	
61	gloves, sterile	SB024					1		0	
62	gloves, non-sterile, nitrile	SB023	0				0		0	
63	gown, staff, impervious	SB027	1				1		0	
64	cover, thermometer probe	SB004	1		1				1	

	A	B	O	P	S	T	W	X	AA	AB
1			2004 Recommendation		2004 Recommendation		2004 Recommendation		2004 Recommendation	
2		Tracking #	H15		H16		H17		H18	
3		CPT code	96413		96415		96416		96417	
4		HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug		Chemotherapy administration, intravenous infusion technique; each additional hour, one to eight (8) hours (List separately in addition to code for primary procedure)(Use 96412 in conjunction with 96410)		Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump		Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to one hour (List separately in addition to code for primary procedure)	
5	LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
93	swab-pad, alcohol	SJ053	2				3		3	
94	povidone swabsticks (3 pack uou)	SJ043					1		1	
95	bandage, strip 0.75in x 3in	SG021	1							
96	needle, 19-25g, butterfly	SC030	1							
97	infusion pump cassette-reservoir	SC013	1				1			
98	iv infusion set	SC018	1						1	
99	synnqe w-needle, OSHA compliant (SafetyGlide)	SC058	3				3		2	
100	synnqe 10-12ml	SC051	1				2		2	
101	syringe 1ml	SC052	1							
102	synnqe 20ml	SC053	1				2		2	
103	syringe 50-60ml	SC056	1							
104	water, sterile inj	SH075	2							
105	angiocatheter 14g-24g	SC001								
106	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068					1		1	
107	gauze, non-sterile 2in x 2in	SG050					2		2	
108	dressing, 4in x 4.75in (Tegaderm)	SG037					1		0	
109	steri-strip (6 strip uou)	SG074					1		1	
110	iv tubing (extension)	SC019	1							
111	battery, 9 volt	SK010					2			
112	synnqe 3ml	SC055								
113	albumin saline	SH004								
114	stop cock, 3-way	SC041								
115	syringe 30 ml	SC054								
116	blood collection bag	SC004								
117	eye shield, non-fox	SG049	0				0		0	
118	sodium chloride, 99.0% min.	SL126	1				1		1	
119	bandage, elastic, self-adherent wrap 1in (Coban)	SG014								
120	pack, minimum multi-specialty visit	SA048	0				0		0	
	needle, Huber point	SC039			0				0	
	syringe with needle, OSHA compliant	SC058								
121	tray, lumbar puncture	SA065								
124	graham crackers, 1 packet	SK040	1		1					
125	juice, apple, 1 oz	SK042	6		6					
126	cup, drinking	SK018	1		1					
127	hepappn 1,000 units-ml inj	SH039	1		1		1		1	
128	Equipment									
129	biohazard hood (\$7,612.00)		22				31		22	
130	chemo couch	E91004	83				100		60	
131	infusion pump	E91001	83						60	
132	exam table	E1001								

A	B	AC	AD	AG	AH	AI	AJ
1		2004 Recommendation		2004 Recommendation		2004 Recommendation	
2	Tracking #	H24		H25		H26	
3	CPT code	96521		96523		96522	
4	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Refilling and maintenance of portable pump		Irrigation of implanted venous access device for drug delivery systems (Do not report 9652X if an injection or infusion is provided on the same day)		Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)	
5	LOCATION	In Office	Out Office	In Office	Out Office	In Office	Out Office
6	GLOBAL PERIOD	XXX		XXX		XXX	
7	TOTAL CLINICAL LABOR TIME	82		16		85	
8	STAFF TYPE L051A=RN, L056A=RN/OCN	L056A		L056A			
9	Total Pre-time	6		0		6	
10	Total Intra-time	70		16		73	
11	Total Post-time	6		0		6	
12	PRE-SERVICE						
13	Start: Following visit when decision for surgery or procedure made						
14	Complete pre-service diagnostic & referral forms	3		0		3	
15	Coordinate pre-surgery services	3		0		3	
16	Office visit before surgery/procedure: Review test and exam results	0		0		0	
17	Provide pre-service education/obtain consent	0		0		0	
18	Follow-up phone calls & prescriptions	0		0		0	
19	Other Clinical Activity (please specify)	0		0		0	
20	End:When patient enters office for surgery/procedure	0		0		0	
21	SERVICE PERIOD						
22	Start: When patient enters office for surgery/procedure	RN/OCN					
23	Pre-service services						
24	treatment & obtain chemotherapy-related medical hx	L056A	4	2		5	
25	Greet patient and provide gowning		2	2		2	
26	Obtain vital signs		3	3		3	
27	(initial education of 1 hr amortized over average of 6 cycles)		3	0		4	
28	Prepare room, equipment, supplies		2	2		2	
29	Prepare and position patient and mix chemotherapy		2	2		2	
30	ix chemotherapy		28	0		17	
31	sedate/apply anesthesia		0	0		0	
48	Intra-service						
49	Perform procedure or Assist physician in performing procedure		8	5		20	
62	Post-Service						
63	Monitor pt. following service/check tubes, monitors, drains		5	0		5	
64	Clean room/equipment by physician staff		3	0		3	
65	Complete medical record documentation, diagnostic forms, lab & X-ray requisitions		5	0		5	
66	Review/read X-ray, lab, and pathology reports		0	0		0	
67	Post procedure education /conditions for which patient should call office (side effects, complications) home care instructions /coordinate office visits /prescriptions		5	0		5	
68	End: Patient leaves office						
69	POST-SERVICE Period						
70	Start: Patient leaves office						
71	Conduct phone calls/call in prescriptions		6			6	
72	Office visits: Greet patient, escort to room; provide gowning; interval history & vital signs and chart; assemble previous test reports/results; assist physician during exam; assist with dressings, wound care, suture removal; prepare dx test, prescription forms; post service education, instruction, counseling; clean room/equip, check supplies; coordinate home or outpatient care						
73	List Number and Level of Office Visits						
74	99211 16 minutes						
75	99212 27 minutes						
76	99213 36 minutes						
77	99214 53 minutes						
78	99215 63 minutes						
79	Other						
80	Total Office Visit Time						
81	Conduct phone calls between office visits						
82	Other Activity (please specify)						
83	End: with last office visit before end of global period						
84	MEDICAL SUPPLIES						
85	drape, non-sterile, sheet 40in x 60in	SB006	1	1		1	
86	gown, patient	SB026					
87	paper, exam table	SB036		7			
88	gloves, non-sterile	SB022	1	1		1	
89	gloves, sterile	SB024	1	1		1	
90	gloves, non-sterile, nitrile	SB023	0	0		0	
91	gown, staff, impervious	SB027	1	0		1	
92	cover, thermometer probe	SB004					

A		B	AC	AD	AG	AH	AI	AJ
		Tracking #	2004 Recommendation		2004 Recommendation		2004 Recommendation	
		CPT code	H24		H25		H26	
			96521		96523		96522	
		HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	Refilling and maintenance of portable pump		Irrigation of implanted venous access device for drug delivery systems (Do not report 9652X if an injection or infusion is provided on the same day)		Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)	
5 LOCATION			In Office	Out Office	In Office	Out Office	In Office	Out Office
93	swab-pad, alcohol	SJ053						
94	povidone swabsticks (3 pack uou)	SJ043						
95	bandage, strip 0.75in x 3in	SG021			1		1	
96	needle, 19-25g, butterfly	SC030						
97	infusion pump cassette-reservoir	SC013	1					
98	iv infusion set	SC018						
99	synnrg w-needle, OSHA compliant (SafetyGlide)	SC058	2		2		3	
100	synnrg 10-12ml	SC051	2		2		2	
101	synnrg 1ml	SC052						
102	synnrg 20ml	SC053	2					
103	synnrg 50-60ml	SC056						
104	water, sterile inj	SH075						
105	angiocatheter 14g-24g	SC001						
106	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068	1		1		1	
107	gauze, non-sterile 2in x 2in	SG050			1		1	
108	dressing, 4in x 4.75in (Tegaderm)	SG037			1			
109	steri-strip (6 strip uou)	SG074						
110	iv tubing (extension)	SC019					1	
111	battery, 9 volt	SK010	2					
112	synnrg 3ml	SC055						
113	albumin saline	SH004						
114	stop cock, 3-way	SC041					1	
115	synnrg 30 ml	SC054					1	
116	blood collection bag	SC004						
117	eye shield, non-fox	SG049	0		0		0	
118	sodium chloride, 99.0% min.	SL126						
119	bandage, elastic, self-adherent wrap 1in (Coban)	SG014						
120	pack, minimum multi-specialty visit	SA048	0		0		0	
	needle, Huber point	SC039	0					
	ynnrg with needle, OSHA compliant	SC058						
	ray, lumbar puncture	SA065						
124	graham crackers, 1 packet	SK040						
125	juice, apple, 1 oz	SK042						
126	cup, drinking	SK018						
127	hepamn 1,000 units-ml inj	SH039			1			
128	<b>Equipment</b>							
129	biohazard hood (\$7,612.00)		31				22	
130	chemo couch	E91004	73				79	
131	infusion pump	E91001						
132	exam table	E1001			20			

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

CPT Code:90760 Tracking Number: H1 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: .17

RUC RVU: 0.17

CPT Descriptor: Intravenous infusion, hydration; initial, up to one hour

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 49 year old female has a diagnosis of viral gastroenteritis. Intravenous hydration is prescribed. A peripheral IV line needs to be established.

Percentage of Survey Respondents who found Vignette to be Typical: 43%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 36%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

## Description of Post-Service Work:

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004
<b>Presenter(s):</b>	ACRH – Elizabeth Tindall, MD AGA – Joel Brill, MD ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD IDSA - Lawrence Martinelli, MD
<b>Specialty(s):</b>	American College of Rheumatology (ACRh) American Gastroenterological Association (AGA) American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO) Infectious Diseases Society of America (IDSA)

<b>CPT Code:</b> 90760					
<b>Sample Size:</b> 377	<b>Resp n:</b> 111		<b>Response:</b> %		
<b>Sample Type:</b> Convenience					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.10	0.45	1.00	1.50	15.00
<b>Pre-Service Evaluation Time:</b>			10.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	1.00	5.00	10.00	15.00	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>5.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99214	XXX	1.10

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	..45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

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

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

**Number of respondents who choose Key Reference Code: 23      % of respondents: 20.7 %**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 90760</u>	<u>Key Reference CPT Code: 99214</u>
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	10.00	25.00
Median Immediate Post-service Time	5.00	13.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00

Median Office Visit Time	0.0	0.00
Median Total Time	25.00	38.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.11	2.96
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.99	2.88
Urgency of medical decision making	3.24	2.71

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.54	2.46
Physical effort required	2.36	2.28

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.94	2.56
Outcome depends on the skill and judgment of physician	2.96	2.86
Estimated risk of malpractice suit with poor outcome	2.87	2.66

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.81	2.57
Intra-Service intensity/complexity	2.79	2.73
Post-Service intensity/complexity	2.66	2.49

**ADDITIONAL RATIONALE**

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

**PROCESS AND PLAYERS**

The American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH) and the Infectious Diseases Society of America (IDSA) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

**CONSENSUS PANEL RECOMMENDATIONS**

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

**Consensus Panel Time Recommendation**

Pre: 2 minutes

Intra: 5 minutes RUC modified to 3 minutes

Post: 2 minutes

Total Time: 9 minutes The RUC modified to 7 minutes

Consensus Panel Work Recommendation: .17 RVU

**CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION**

The Consensus Panel compared CPT code 90760 to other RUC-surveyed codes.

The Workgroup considered a crosswalk to CPT code 99211. CPT code 99211 has a value of .17 RVU and is similar to 90760 in physician work, technical skill, effort and time with the patient. The Consensus Panel concluded that 99211 was a reasonable crosswalk. The Workgroup identified several other RUC-surveyed codes that provided additional support for the reasonableness of the recommendation.

CODE	DESCRIPTOR	TIME	RVU
99211	E/M – Level 1	(Pre=0/Intra=5/Post=2)	.17
90471	Immunization administration	(Pre=0/Intra=7/Post=0)	.17
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

Once the Workgroup agreed to the value of .17 for 90760, the remaining codes in the family were discussed relative to this value.

The Consensus Panel also discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel composed of physicians from multiple specialties concluded that they had made a reasonable argument for a value of .17 RVU for CPT code 90760. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

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

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



**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No  
If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 90780.  
Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

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

CPT Code: +90761 Tracking Number: H2 Global Period: ZZZ

**Recommended Work Relative Value**

Specialty Society RVU: .13

RUC RVU: 0.09

CPT Descriptor: Intravenous infusion, hydration; each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure) (Use +90761 in conjunction with code 90760)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 49 year old female with a diagnosis of viral gastroenteritis has two liters of IV hydration prescribed. At the end of the first hour another 1500cc remain to be infused and the infusion is continued. (This is an add-on code: the 90780X1 code includes the IV discontinuation, flush and discharge process.)

Percentage of Survey Respondents who found Vignette to be Typical: 64%

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

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- No physician pre-service work

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

## Description of Post-Service Work:

- No physician post-service work

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004
<b>Presenter(s):</b>	ACRH – Elizabeth Tindall, MD AGA – Joel Brill, MD ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD IDSA - Lawrence Martinelli, MD
<b>Specialty(s):</b>	American College of Rheumatology (ACR <sup>h</sup> ) American Gastroenterological Association (AGA) American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO) Infectious Diseases Society of America (IDSA)
<b>CPT Code:</b>	+90761

<b>Sample Size:</b> 377	<b>Resp n:</b> 74	<b>Response:</b> 19.62 %			
<b>Sample Type:</b> Convenience					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.10	0.17	0.44	1.06	3.28
<b>Pre-Service Evaluation Time:</b>			5.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	1.00	3.00	5.00	10.00	240.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>5.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 23      % of respondents: 31.0 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: +90761</u>	<u>Key Reference CPT Code: 99211</u>
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	5.00	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	15.00	7.00

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.54	2.40
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.35	2.27
--	------	------

Urgency of medical decision making	2.61	2.38
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.25	2.13
--------------------------	------	------

Physical effort required	2.04	2.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.63	2.19
---	------	------

Outcome depends on the skill and judgment of physician	2.62	2.38
--	------	------

Estimated risk of malpractice suit with poor outcome	2.53	2.35
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.45	2.27
----------------------------------	------	------

Intra-Service intensity/complexity	2.39	2.25
------------------------------------	------	------

Post-Service intensity/complexity	2.53	2.14
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

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

**PROCESS AND PLAYERS**

The American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH) and the Infectious Diseases Society of America (IDSA), conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA), and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 0 minutes

Intra: 5 minutes RUC modified to 3 minutes

Post: 0 minutes

Total Time: 5 minutes RUC modified to 3 minutes

Consensus Panel Work Recommendation: .13 RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 90760.

The Consensus Panel compared CPT code 90760 to other RUC-surveyed codes.

The Workgroup considered a crosswalk to CPT code 99211. CPT code 99211 has a value of .17 RVU and is similar to 90760 in physician work, technical skill, effort and time with the patient. The Consensus Panel concluded that 99211 was a reasonable crosswalk. The Workgroup identified several other RUC-surveyed that provided additional support for the reasonableness of the recommendation of .17RVU for CPT code 90760.

CODE	DESCRIPTOR	TIME	RVU
99211	E/M – Level 1	(Pre=0/Intra=5/Post=2)	.17
90471	Immunization administration	(Pre=0/Intra=7/Post=0)	.17
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

Once the Workgroup agreed to the value of .17 for 90760, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE SUPPORTING RECOMMENDATION (+90761 - .13RVU)

By extension, +90780X2, which is an add-on code to 90760, was felt to deserve a lower RVU and this is reflected in the RVU value chosen. Since +90761 is billed in conjunction with 90760, there is no pre- or post-service time with this code. The Consensus Panel also discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel composed of physicians from multiple specialties concluded that they had made a reasonable argument for a value of .13 RVU for CPT code +90761. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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



**Professional Liability Insurance Information (PLI)**

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

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 90781.

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

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

CPT Code:90765 Tracking Number: H3 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: .24

RUC RVU: 0.21

CPT Descriptor: Intravenous infusion, for therapy/diagnosis, (specify substance or drug); initial, up to one hour

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 69 year old male presents with a history of a left olecranon bursitis due to oxacillin-resistant Staphylococcus aureus. He is receiving daily infusions on an outpatient basis and has been clinically improving. A PICC line has been previously established (placement of the PICC line is reported separately).

Percentage of Survey Respondents who found Vignette to be Typical: 57%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 2%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

## Description of Post-Service Work:

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004				
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD IDSA - Lawrence Martinelli, MD				
<b>Specialty(s):</b>	American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO) Infectious Diseases Society of America (IDSA)				
<b>CPT Code:</b>	90765				
<b>Sample Size:</b>	174	<b>Resp n:</b>	46	<b>Response:</b>	26.43 %
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.11	0.49	0.90	1.49	3.00

Pre-Service Evaluation Time:				10.0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		2.00	5.00	10.00	15.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
Immed. Post-time:	<u>6.00</u>					
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

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

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

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

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

Number of respondents who choose Key Reference Code: 10      % of respondents: 21.7 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 90765</u>	<u>Key Reference CPT Code: 99211</u>
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	10.00	5.00
Median Immediate Post-service Time	6.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	26.00	7.00

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.23	2.80
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.22	2.78
--	------	------

Urgency of medical decision making	3.07	2.60
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.61	2.28
--------------------------	------	------

Physical effort required	2.24	2.02
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.72	2.69
---	------	------

Outcome depends on the skill and judgment of physician	3.54	2.89
--	------	------

Estimated risk of malpractice suit with poor outcome	3.54	2.76
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.33	2.64
----------------------------------	------	------

Intra-Service intensity/complexity	3.04	2.78
------------------------------------	------	------

Post-Service intensity/complexity	2.91	2.51
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

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

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH) and the Infectious Diseases Society of America (IDSA) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 2 minutes

Intra: 5 minutes

Post: 2 minutes

Total Time: 9 minutes

Consensus Panel Work Recommendation: .24 RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 90760.

The Workgroup considered a crosswalk to CPT code 99211. CPT code 99211 has a value of .17 RVU and is similar to 90760 in physician work, technical skill, effort and time with the patient. The Consensus Panel concluded that 99211 was a reasonable crosswalk. The Workgroup identified several other RUC-surveyed that provided additional support for the reasonableness of the recommendation of .17RVU for CPT code 90765.

CODE	DESCRIPTOR	TIME	RVU
99211	E/M - Level 1	(Pre=0/Intra=5/Post=2)	.17
90471	Immunization administration	(Pre=0/Intra=7/Post=0)	.17
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

Once the Workgroup agreed to the value of .17 for 90760, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE SUPPORTING RECOMMENDATION (90765 - .24RVU)

This code represents up to one hour of infusion of a drug under the physician's supervision. The Intensity/Complexity Measures in the survey data reflect this increased level of service. The Consensus Panel further felt that the provision of a drug with the infusion justifies the increased RVU which was assigned to this code. There is a risk of adverse reactions for this procedure. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .24 RVU for CPT code 90765. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.



**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 90780.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: +90766 Tracking Number: H5 Global Period: ZZZ

**Recommended Work Relative Value**

Specialty Society RVU: .21

RUC RVU: 0.18

CPT Descriptor: Intravenous infusion, for therapy/diagnosis, (specify substance or drug); each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)

(Report +90767, 90766 in conjunction with code 90765)

(Report +90766 for additional hour(s) of sequential infusion)

(Report +90766 for infusion intervals of greater than thirty minutes beyond one hour increments)

(Report +90767 or +90766 to identify additional hour(s) of substance/drug infusion, or +90761 for hydration infusion, if provided as a secondary or subsequent service after a different initial service is provided)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 32 year old male insulin-dependent diabetic, who is status post renal transplantation, is receiving liposomal Amphotericin B infusion for Cryptococcus meningitis through an established PICC line. He is now to receive another hour of infusion. (This is an add-on code: the 9078X1 code includes the IV discontinuation, flush and discharge process.)

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- No physician pre-service work

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

## Description of Post-Service Work:

- No physician post-service work

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2005		
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD IDSA - Lawrence Martinelli, MD		
<b>Specialty(s):</b>	American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO) Infectious Diseases Society of America (IDSA)		
<b>CPT Code:</b>	+90766		
<b>Sample Size:</b>	174	<b>Resp n:</b> 41	<b>Response:</b> 23.56 %
<b>Sample Type:</b>	Convenience		

	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.15	0.20	<b>0.63</b>	1.46	3.20
<b>Pre-Service Evaluation Time:</b>			<b>5.0</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.0</b>		
<b>Intra-Service Time:</b>	0.00	3.00	<b>5.00</b>	10.00	150.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u><b>5.00</b></u>				
<b>Critical Care time/visit(s):</b>	<u><b>0.0</b></u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u><b>0.0</b></u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u><b>0.0</b></u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u><b>0.0</b></u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14      % of respondents: 34.1 %

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: +90766</u>	<u>Key Reference CPT Code: 99211</u>
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	5.00	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	15.00	7.00

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.95	2.71
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.76	2.71
--	------	------

Urgency of medical decision making	2.98	2.40
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.54	2.29
--------------------------	------	------

Physical effort required	2.12	1.98
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.28	2.56
---	------	------

Outcome depends on the skill and judgment of physician	3.15	2.71
--	------	------

Estimated risk of malpractice suit with poor outcome	3.29	2.66
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.93	2.50
----------------------------------	------	------

Intra-Service intensity/complexity	3.00	2.58
------------------------------------	------	------

Post-Service intensity/complexity	2.75	2.40
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH) and the Infectious Diseases Society of America (IDSA), conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 0 minute

Intra: 5 minutes RUC modified to 3 minutes

Post: 0 minutes

Total Time: 5 minutes RUC modified to 3 minutes

Consensus Panel Work Recommendation: .21 RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 90760.

The Workgroup considered a crosswalk to CPT code 99211. CPT code 99211 has a value of .17 RVU and is similar to 90760 in physician work, technical skill, effort and time with the patient. The Consensus Panel concluded that 99211 was a reasonable crosswalk. The Workgroup identified several other RUC-surveyed that provided additional support for the reasonableness of the recommendation of .17RVU for CPT code 90765.

CODE	DESCRIPTOR	TIME	RVU
99211	E/M – Level 1	(Pre=0/Intra=5/Post=2)	.17
90471	Immunization administration	(Pre=0/Intra=7/Post=0)	.17
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

Once the Workgroup agreed to the value of .17 for 90760, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE SUPPORTING RECOMMENDATION (+90766 - .21RVU)

This code describes the continuation of the infusion of a drug beyond the first hour. It is an add-on code to 90765, and thus the pre and post work is captured in the base code. There is a risk of adverse reaction for this procedure. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .21 RVU for CPT code +90766. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.



**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 90781.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: +90767 Tracking Number: H4 Global Period: ZZZ

**Recommended Work Relative Value**

Specialty Society RVU: .21

RUC RVU: 0.19

CPT Descriptor: ntravenous infusion, for therapy/diagnosis, (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for primary procedure)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 70 year old female status post a ruptured colonic diverticula presents for infusion of two drugs. She has a single lumen PICC line in place. (This is an add-on code: the 9078X1 code includes the IV discontinuation, flush and discharge process.)

Percentage of Survey Respondents who found Vignette to be Typical: 64%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Physician confirms orders

**Description of Intra-Service Work:**

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

**Description of Post-Service Work:**

- No physician post-service work

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004				
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD IDSA - Lawrence Martinelli, MD				
<b>Specialty(s):</b>	American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO) Infectious Diseases Society of America (IDSA)				
<b>CPT Code:</b>	+90767				
<b>Sample Size:</b>	174	<b>Resp n:</b>	42	<b>Response:</b>	24.13 %
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.10	0.22	1.00	1.40	3.00
<b>Pre-Service Evaluation Time:</b>			6.0		
<b>Pre-Service Positioning Time:</b>			0.0		

<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		1.00	3.75	<b>5.50</b>	13.50	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u><b>5.00</b></u>					
<b>Critical Care time/visit(s):</b>	<u><b>0.0</b></u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u><b>0.0</b></u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u><b>0.0</b></u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u><b>0.0</b></u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 13      % of respondents: 30.9 %**

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: +90767</u>	<u>Key Reference CPT Code: 99211</u>
Median Pre-Service Time	6.00	0.00
Median Intra-Service Time	5.50	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	16.50	7.00

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.15	2.88
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.15	2.90
--	------	------

Urgency of medical decision making	3.12	2.63
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.61	2.32
--------------------------	------	------

Physical effort required	2.17	2.02
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.39	2.60
---	------	------

Outcome depends on the skill and judgment of physician	3.24	2.78
--	------	------

Estimated risk of malpractice suit with poor outcome	3.32	2.56
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	2.68
----------------------------------	------	------

Intra-Service intensity/complexity	2.95	2.75
------------------------------------	------	------

Post-Service intensity/complexity	2.92	2.63
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH) and the Infectious Diseases Society of America (IDSA), conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 1 minute

Intra: 5 minutes

Post: 0 minutes

Total Time: 6 minutes

Consensus Panel Work Recommendation: .21 RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 90760.

The Workgroup considered a crosswalk to CPT code 99211. CPT code 99211 has a value of .17 RVU and is similar to 90760 in physician work, technical skill, effort and time with the patient. The Consensus Panel concluded that 99211 was a reasonable crosswalk. The Workgroup identified several other RUC-surveyed that provided additional support for the reasonableness of the recommendation of .17RVU for CPT code 90765.

CODE	DESCRIPTOR	TIME	RVU
99211	E/M - Level 1	(Pre=0/Intra=5/Post=2)	.17
90471	Immunization administration	(Pre=0/Intra=7/Post=0)	.17
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

Once the Workgroup agreed to the value of .17 for 90760, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE SUPPORTING RECOMMENDATION (+90767 - .21RVU)

This code describes the sequential infusion of a drug after the initial 90765 service. The physician work for this infusion parallels that of 90765, however the pre-service work is less, and the post-service work is accounted for in the base code, 90765. There is a risk of adverse reactions for this procedure. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .21 RVU for CPT code +90767. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.



**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 90781.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: +90768 Tracking Number: H6 Global Period: ZZZ

**Recommended Work Relative Value**

Specialty Society RVU: .17

RUC RVU: 0.17

CPT Descriptor: Intravenous infusion, for therapy/diagnosis, (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure) (report only once per substance/drug, regardless of duration) (Report +90768 in conjunction with code 90765 or 96413)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 73 year old patient with a diabetic ulcer and osteomyelitis presents for infusion. His wound culture was positive for several bacteria, including oxacillin-resistant Staphylococcus aureus. He is to receive an infusion of two antibiotics simultaneously through his previously established two lumen central catheter. (This is an add-on code: the 9078X1 code includes the IV discontinuation, flush and discharge process.)

Percentage of Survey Respondents who found Vignette to be Typical: 66%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- Physician provides and confirms orders

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

## Description of Post-Service Work:

- No physician post-service work

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD				
	ASH - Samuel H. Silver, MD, PhD				
	IDSA - Lawrence Martinelli, MD				
<b>Specialty(s):</b>	American Society of Hematology (ASH)				
	American Society of Clinical Oncology (ASCO)				
	Infectious Diseases Society of America (IDSA)				
<b>CPT Code:</b>	+90768				
<b>Sample Size:</b>	174	<b>Resp n:</b>	35	<b>Response:</b> 20.11 %	
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.15	0.24	1.00	1.50	3.40
<b>Pre-Service Evaluation Time:</b>			9.0		

Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		1.00	3.00	7.00	14.25	100.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
Immed. Post-time:	<u>5.00</u>					
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 23      % of respondents: 66.0 %**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: +90768</u>	<u>Key Reference CPT Code: 99211</u>
Median Pre-Service Time	9.00	0.00
Median Intra-Service Time	7.00	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	21.00	7.00

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.43	2.94
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.44	3.00
--	------	------

Urgency of medical decision making	3.34	2.80
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.94	2.57
--------------------------	------	------

Physical effort required	2.34	2.17
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.77	2.77
---	------	------

Outcome depends on the skill and judgment of physician	3.54	2.91
--	------	------

Estimated risk of malpractice suit with poor outcome	3.49	2.69
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.37	2.60
----------------------------------	------	------

Intra-Service intensity/complexity	3.09	2.63
------------------------------------	------	------

Post-Service intensity/complexity	3.11	2.49
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH) and the Infectious Diseases Society of America (IDSA), conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA), and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 1 minute

Intra: 3 minutes

Post: 0 minutes

Total Time: 4 minutes

Consensus Panel Work Recommendation: .22 RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 90760.

The Workgroup considered a crosswalk to CPT code 99211. CPT code 99211 has a value of .17 RVU and is similar to 90760 in physician work, technical skill, effort and time with the patient. The Consensus Panel concluded that 99211 was a reasonable crosswalk. The Workgroup identified several other RUC-surveyed that provided additional support for the reasonableness of the recommendation of .17RVU for CPT code 90765.

CODE	DESCRIPTOR	TIME	RVU
99211	E/M - Level 1	(Pre=0/Intra=5/Post=2)	.17
90471	Immunization administration	(Pre=0/Intra=7/Post=0)	.17
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

Once the Workgroup agreed to the value of .17 for 90760, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE SUPPORTING RECOMMENDATION (+90768 - .22RVU)

This code describes the concurrent administration of more than one drug to a patient. Since it is to be used in conjunction with 90765, the pre-service work is thus partly accounted for by 90765, and there is no post-service work involved with this code. The Consensus Panel felt that the intensity of service due to the potential additive and/or toxicities, drug interactions and adverse effects of simultaneous drug administration justifies a higher RVU than for continuing or sequential drug administration. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .22 RVU for CPT code +90768. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. BASE CODE: 90765; ADD-ON CODES: +90767, +90766, +90768

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) **TO BE SUBMITTED IN A SEPARATE ATTACHMENT**

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty	How often?
Specialty	How often?
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0  
 If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 90781.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:90772 Tracking Number: H7 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: .17

RUC RVU: 0.17

CPT Descriptor: Therapeutic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular  
(For administration of vaccines/toxoids, see 90471-90472)

(Report 90772 for non-antineoplastic hormonal therapy injections)

(Report 96401 for anti-neoplastic hormonal injection therapy)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 19 year old male presents with severe dysuria. A urethral swab is performed and found to be consistent with gonorrhea

Percentage of Survey Respondents who found Vignette to be Typical: 17%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 2%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician assesses patient's response to treatment

## Description of Post-Service Work:

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004		
<b>Presenter(s):</b>	ACRH – Elizabeth Tindall, MD ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD		
<b>Specialty(s):</b>	American College of Rheumatology (ACR <sub>h</sub> ) American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO)		
<b>CPT Code:</b>	90772		
<b>Sample Size:</b>	263	<b>Resp n:</b> 58	<b>Response:</b> 22.05 %

Sample Type: Convenience		Low	25 <sup>th</sup> pctl	Median*	75th pctl	High
Survey RVW:		0.10	0.17	0.63	1.20	2.20
Pre-Service Evaluation Time:				5.0		
Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		0.00	2.00	5.00	15.00	60.00
Post-Service	Total Min**	CPT code / # of visits				
Immed. Post-time:	<u>5.00</u>	-				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 22      % of respondents: 38.0 %**

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 90772</u>	<u>Key Reference CPT Code: 99211</u>
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	5.00	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	15.00	7.00

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.91	2.49
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.77	2.51
--	------	------

Urgency of medical decision making	2.77	2.37
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.33	2.25
--------------------------	------	------

Physical effort required	2.12	2.09
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.89	2.40
---	------	------

Outcome depends on the skill and judgment of physician	2.78	2.49
--	------	------

Estimated risk of malpractice suit with poor outcome	2.86	2.42
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.61	2.25
----------------------------------	------	------

Intra-Service intensity/complexity	2.39	2.34
------------------------------------	------	------

Post-Service intensity/complexity	2.48	2.27
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 2 minute

Intra: 3 minutes

Post: 2 minutes

Total Time: 7 minutes

Consensus Panel Work Recommendation: .17 RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 90760.

The Workgroup considered a crosswalk to CPT code 99211. CPT code 99211 has a value of .17 RVU and is similar to 90760 in physician work, technical skill, effort and time with the patient. The Consensus Panel concluded that 99211 was a reasonable crosswalk. The Workgroup identified several other RUC-surveyed that provided additional support for the reasonableness of the recommendation of .17RVU for CPT code 90765.

CODE	DESCRIPTOR	TIME	RVU
99211	E/M – Level 1	(Pre=0/Intra=5/Post=2)	.17
90471	Immunization administration	(Pre=0/Intra=7/Post=0)	.17
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

Once the Workgroup agreed to the value of .17 for 90760, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE SUPPORTING RECOMMENDATION (90772 - .17RVU)

The Consensus Panel agreed that a straightforward crosswalk to CPT code 99211 correctly reflected the level of physician work for this procedure and resulted in a reasonable value of .17 RVU. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .17 RVU for CPT code 90772. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty	How often?
Specialty	How often?
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0  
 If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency	Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 90782

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:90774 Tracking Number: H9 Global Period: XXX

**Recommended Work Relative Value**  
Specialty Society RVU: .20  
RUC RVU: **0.18**

CPT Descriptor: Therapeutic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug (90772-90774 do not include injections for allergen immunotherapy. For allergen immunotherapy injections, see 95115-95117)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 58 year old woman with no major underlying health problems presents for evaluation of nausea and vomiting, She is diagnosed with Gastroenteritis with mild dehydration. An intravenous anti-emetic is prescribed, along with one liter of IV hydration. (Liter of hydration is separately reported.)

Percentage of Survey Respondents who found Vignette to be Typical: 28%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

## Description of Post-Service Work:

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004		
<b>Presenter(s):</b>	ACRH – Elizabeth Tindall, MD ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD		
<b>Specialty(s):</b>	American College of Rheumatology (ACRh) American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO)		
<b>CPT Code:</b>	90774		
<b>Sample Size:</b>	263	<b>Resp n:</b> 64	<b>Response:</b> 24.33 %
<b>Sample Type:</b>	Convenience		

	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
<b>Survey RVW:</b>	0.15	0.25	<b>0.72</b>	1.48	3.00
<b>Pre-Service Evaluation Time:</b>			<b>6.0</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.0</b>		
<b>Intra-Service Time:</b>	0.00	4.50	<b>6.50</b>	15.00	240.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u><b>5.00</b></u>				
<b>Critical Care time/visit(s):</b>	<u><b>0.0</b></u>	99291x 0.0 99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u><b>0.0</b></u>	99231x 0.0 99232x 0.0 99233x 0.0			
<b>Discharge Day Mgmt:</b>	<u><b>0.0</b></u>	99238x 0.00 99239x 0.00			
<b>Office time/visit(s):</b>	<u><b>0.0</b></u>	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0			

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15      % of respondents: 23.0 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 90774</u>	<u>Key Reference CPT Code: 99211</u>
Median Pre-Service Time	6.00	0.00
Median Intra-Service Time	6.50	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	17.50	7.00

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.44	2.73
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.09	2.70
--	------	------

Urgency of medical decision making	3.39	2.61
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.79	2.62
--------------------------	------	------

Physical effort required	2.46	2.34
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.47	2.69
---	------	------

Outcome depends on the skill and judgment of physician	3.31	2.82
--	------	------

Estimated risk of malpractice suit with poor outcome	3.25	2.67
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.13	2.56
----------------------------------	------	------

Intra-Service intensity/complexity	3.05	2.67
------------------------------------	------	------

Post-Service intensity/complexity	2.80	2.41
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American College of Rheumatology (ACR<sup>h</sup>), American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA), and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 2 minute

Intra: 5 minutes

Post: 2 minutes

Total Time: 9 minutes

Consensus Panel Work Recommendation: .20 RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 90760.

The Workgroup considered a crosswalk to CPT code 99211. CPT code 99211 has a value of .17 RVU and is similar to 90760 in physician work, technical skill, effort and time with the patient. The Consensus Panel concluded that 99211 was a reasonable crosswalk. The Workgroup identified several other RUC-surveyed that provided additional support for the reasonableness of the recommendation of .17RVU for CPT code 90765.

CODE	DESCRIPTOR	TIME	RVU
99211	E/M - Level 1	(Pre=0/Intra=5/Post=2)	.17
90471	Immunization administration	(Pre=0/Intra=7/Post=0)	.17
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

Once the Workgroup agreed to the value of .17 for 90760, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE SUPPORTING RECOMMENDATION (90774 - .20RVU)

This code describes the intravenous push of a drug. The Consensus Panel felt that the intensity of service for this code exceeds that of a saline hydration, but is not quite equivalent to that of the other infusion codes that include drug administration. The physician work includes pre-, intra- and post service physician time. There is a risk of adverse reactions for this procedure. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .20 RVU for CPT code 90774. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.



**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 90784.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

**Recommended Work Relative Value**

CPT Code: +90775 Tracking Number: H10 Global Period: ZZZ

Specialty Society RVU: .16

RUC RVU: 0.10

CPT Descriptor: Therapeutic or diagnostic injection (specify substance or drug); each additional sequential intravenous push (List separately in addition to code for primary procedure)

(Use +90775 in conjunction with code 90774)

(Report +90775 to report an intravenous push subsequent or concurrent to a hydration or therapeutic/diagnostic infusion)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 58 year old woman with no major underlying health problems presents for evaluation of nausea and vomiting, diagnosed as having gastroenteritis with mild dehydration. An intravenous anti-emetic is prescribed, along with one liter of IV hydration. The nausea persists and the physician prescribes a benzodiazepine by IV push. (The physician evaluations are reported separately. Hydration is reported separately.) (This is an add-on code: the 90784 code includes the IV discontinuation, flush and discharge process.)

Percentage of Survey Respondents who found Vignette to be Typical: 54%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 2%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- Physician provides and confirms orders

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

## Description of Post-Service Work:

- No physician post-service work

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004				
<b>Presenter(s):</b>	ACRH – Elizabeth Tindall, MD ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD				
<b>Specialty(s):</b>	American College of Rheumatology (ACRh) American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO)				
<b>CPT Code:</b>	+90775				
<b>Sample Size:</b>	263	<b>Resp n:</b>	54	<b>Response:</b>	20.53 %
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>

<b>Survey RVW:</b>	0.15	0.25	<b>0.60</b>	1.48	5.00
<b>Pre-Service Evaluation Time:</b>			<b>5.0</b>		
<b>Pre-Service Positioning Time:</b>			<b>0.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>0.0</b>		
<b>Intra-Service Time:</b>	0.00	3.00	<b>6.00</b>	15.00	240.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u><b>5.00</b></u>				
<b>Critical Care time/visit(s):</b>	<u><b>0.0</b></u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u><b>0.0</b></u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u><b>0.0</b></u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u><b>0.0</b></u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12      % of respondents: 22.0 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: +90775</u>	<u>Key Reference CPT Code: 99211</u>
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	6.00	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	16.00	7.00

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.24	2.78
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.02	2.80
--	------	------

Urgency of medical decision making	3.42	2.69
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.89	2.68
--------------------------	------	------

Physical effort required	2.56	2.44
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.45	2.72
---	------	------

Outcome depends on the skill and judgment of physician	3.37	2.83
--	------	------

Estimated risk of malpractice suit with poor outcome	3.37	2.65
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.02	2.48
----------------------------------	------	------

Intra-Service intensity/complexity	3.06	2.79
------------------------------------	------	------

Post-Service intensity/complexity	3.00	2.50
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American College of Rheumatology (ACR<sup>h</sup>), American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 1 minute

Intra: 5 minutes RUC modified to 3 minutes

Post: 0 minutes

Total Time: 6 minutes RUC modified to 4 minutes

Consensus Panel Work Recommendation: .16 RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 90760.

The Workgroup considered a crosswalk to CPT code 99211. CPT code 99211 has a value of .17 RVU and is similar to 90760 in physician work, technical skill, effort and time with the patient. The Consensus Panel concluded that 99211 was a reasonable crosswalk. The Workgroup identified several other RUC-surveyed that provided additional support for the reasonableness of the recommendation of .17RVU for CPT code 90765.

CODE	DESCRIPTOR	TIME	RVU
99211	E/M - Level 1	(Pre=0/Intra=5/Post=2)	.17
90471	Immunization administration	(Pre=0/Intra=7/Post=0)	.17
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

Once the Workgroup agreed to the value of .17 for 90760, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE SUPPORTING RECOMMENDATION (+90775 - .16 RVU)

This code describes the additional intravenous push of a drug after an initial intravenous push administration. The code is to be used in conjunction with 90774. The physician work for this infusion parallels that of 90774, however the pre-service work is less, and the post-service work is accounted for in the 90774, the base code. There is a risk of adverse reactions for this procedure. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .16 RVU for CPT code +90775. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. BASE CODE: 90774; ADD-ON CODE: +90775

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) **TO BE SUBMITTED IN A SEPARATE ATTACHMENT**

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty	How often?
Specialty	How often?
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0  
 If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 90781.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:96401 Tracking Number: H11 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: .21

RUC RVU: 0.21

CPT Descriptor: Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 34-year old patient with testicular cancer who has the appropriate indications for chemotherapy.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? Yes

## Description of Pre-Service Work:

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff
- Physician confirms and reviews lab results as necessary

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician assesses patient's response to treatment

## Description of Post-Service Work:

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2005				
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD				
	ASH - Samuel H. Silver, MD, PhD				
<b>Specialty(s):</b>	American Society of Hematology (ASH)				
	American Society of Clinical Oncology (ASCO)				
<b>CPT Code:</b>	96401				
<b>Sample Size:</b>	145	<b>Resp n:</b>	40	<b>Response:</b>	27.58 %
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.17	0.41	0.95	1.50	2.58
<b>Pre-Service Evaluation Time:</b>			5.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	1.00	5.00	5.00	10.00	40.00

<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>
<b>Immed. Post-time:</b>	<b><u>5.00</u></b>	
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0 99292x 0.0
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0 99232x 0.0 99233x 0.0
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00 99239x 0.00
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9      % of respondents: 22.5 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 96401	Key Reference CPT Code: 99211
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	5.00	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	15.00	7.00

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.55	3.08
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.48	2.97
--	------	------

Urgency of medical decision making	3.13	2.73
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.75	2.65
--------------------------	------	------

Physical effort required	2.15	2.15
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.78	2.68
---	------	------

Outcome depends on the skill and judgment of physician	3.70	3.13
--	------	------

Estimated risk of malpractice suit with poor outcome	3.55	2.98
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.34	2.73
----------------------------------	------	------

Intra-Service intensity/complexity	2.98	2.90
------------------------------------	------	------

Post-Service intensity/complexity	2.95	2.60
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 4 minutes

Intra: 3 minutes

Post: 2 minutes

Total Time: 9 minutes

Consensus Panel Work Recommendation: .21RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre=10/Intra=15/Post=5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 RVU for CPT code 96401.

Once the Workgroup agreed to the value of .21 RVU for 96401, the remaining codes in the family were discussed relative to this value.

There is a risk of adverse reactions for this procedure. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .21 RVU for CPT code 96401. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES



**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 96408

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 96402 Tracking Number: H12 Global Period: XXX  
 Recommended Work Relative Value  
 Specialty Society RVU: .19  
 RUC RVU: 0.19  
 CPT Descriptor: Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 72-year-old man with prostate cancer who has the appropriate indications for LHRH agonist therapy.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 3%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- Physician provides and confirms orders.
- Physician interacts and reviews plan with staff

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician assesses patient's response to treatment

## Description of Post-Service Work:

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>	ASH - Samuel H. Silver, MD, PhD AUA – Dr. Cooper and Dr.Regan				
<b>Specialty(s):</b>	American Society of Hematology (ASH) American Urological Association (AUA)				
<b>CPT Code:</b>	96402				
<b>Sample Size:</b>	729	<b>Resp n:</b>	62	<b>Response:</b>	8.50 %
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.17	0.45	0.60	1.10	3.80
<b>Pre-Service Evaluation Time:</b>			5.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	0.00	5.00	5.00	10.00	30.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			

<b>Immed. Post-time:</b>	<b><u>5.00</u></b>	
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0 99292x 0.0
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0 99232x 0.0 99233x 0.0
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00 99239x 0.00
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	0.45

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21      % of respondents: 33.8 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 96402	Key Reference CPT Code: 99212
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	5.00	10.00
Median Immediate Post-service Time	5.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00

Median Office Visit Time	0.0	0.00
Median Total Time	15.00	15.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.93	3.32
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.95	2.76
--	------	------

Urgency of medical decision making	2.61	2.69
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.56	2.52
--------------------------	------	------

Physical effort required	2.44	3.08
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.61	3.08
---	------	------

Outcome depends on the skill and judgment of physician	2.82	3.18
--	------	------

Estimated risk of malpractice suit with poor outcome	2.66	2.72
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.79	2.63
----------------------------------	------	------

Intra-Service intensity/complexity	2.82	2.66
------------------------------------	------	------

Post-Service intensity/complexity	2.81	2.60
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## PROCESS AND PLAYERS

The American Urological Association (AUA) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA), and the American Urological Association (AUA).

## CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

### Consensus Panel Time Recommendation

Pre: 4 minutes

Intra: 3 minutes

Post: 2 minutes

Total Time: 9 minutes

Consensus Panel Work Recommendation: .19RVU

## CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre = 10/Intra = 15/Post = 5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre = 5/Intra = 5/Post = 10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 9640X1.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

## EVIDENCE FOR THIS RECOMMENDATION

CPT code 96402 represents an intramuscular or subcutaneous injection of a hormonal chemotherapeutic agent. The work is identical to that described in 96401, as is the post-service work. Since the adverse effects of a hormonal agent are less than that of a chemotherapeutic agent and the surveyed mental effort and judgment and psychological stress reflect this as well, this code was valued less than 96401.

There is a risk of adverse reactions for this procedure. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.



Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 96408.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:96409 Tracking Number: H13 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: .27

RUC RVU: **0.24**

CPT Descriptor: Chemotherapy administration, subcutaneous or intramuscular; intravenous, push technique, single or initial substance/drug

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 67 year old male with bladder cancer presents for an IV push The patient does not have a venous access device and requires an IV initiation.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 2%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff
- Physician confirms and reviews any appropriate lab results as necessary
- Physician calculates dose

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician assesses patient's response to treatment

## Description of Post-Service Work:

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD				
	ASH - Samuel H. Silver, MD, PhD				
<b>Specialty(s):</b>	American Society of Hematology (ASH)				
	American Society of Clinical Oncology (ASCO)				
<b>CPT Code:</b>	96409				
<b>Sample Size:</b>	145	<b>Resp n:</b>	41	<b>Response:</b>	28.27 %
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.17	0.50	0.90	1.33	3.75
<b>Pre-Service Evaluation Time:</b>			10.0		
<b>Pre-Service Positioning Time:</b>			0.0		

<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		2.00	5.00	<b>10.00</b>	15.00	55.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b><u>7.00</u></b>					
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	0.45

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13      % of respondents: 31.7 %

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 96409	Key Reference CPT Code: 99212
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	10.00	10.00
Median Immediate Post-service Time	7.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00

Median Office Visit Time	0.0	0.00
Median Total Time	27.00	15.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.75	3.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.68	3.00
--	------	------

Urgency of medical decision making	3.46	2.83
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.58	2.90
--------------------------	------	------

Physical effort required	2.73	2.35
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.20	2.93
---	------	------

Outcome depends on the skill and judgment of physician	4.08	3.10
--	------	------

Estimated risk of malpractice suit with poor outcome	3.78	2.90
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.75	2.75
----------------------------------	------	------

Intra-Service intensity/complexity	3.35	2.93
------------------------------------	------	------

Post-Service intensity/complexity	3.50	2.68
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## PROCESS AND PLAYERS

The American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

## CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

### Consensus Panel Time Recommendation

Pre: 4 minutes

Intra: 5 minutes

Post: 2 minutes

Total Time: 11 minutes

Consensus Panel Work Recommendation: .27RVU

## CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre = 10/Intra = 15/Post = 5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre = 5/Intra = 5/Post = 10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 96401.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

## EVIDENCE FOR THIS RECOMMENDATION

CPT code 96408 is meant to reflect the work involved in providing chemotherapy administration via an intravenous push. The provision of this service involved more time than 90774, because chemotherapy administration requires reviews of laboratory studies and review of the calculation of the dose to be administered, work that is not required in 90774. Furthermore this service involves a higher intensity of service and greater potential for adverse reactions and liability than the administration of drugs delivered in 90774. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.



Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to existing code 96408.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: +96411 Tracking Number: H14 Global Period: ZZZ

**Recommended Work Relative Value**

Specialty Society RVU: .23

RUC RVU: 0.20

CPT Descriptor: Chemotherapy administration, subcutaneous or intramuscular; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)

(Use +964X1 in conjunction with code 96408)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 67 year old male with bladder cancer is to receive the 2nd drug for that day's treatment. The patient has just finished receiving an IV push of a first drug (reported separately under 96408) as part of the chemotherapy course. (This is an add-on code: the 96408 code includes the IV discontinuation, flush and discharge process.)

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 3%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- Physician provides and confirms orders
- Physician calculates dose

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician assesses patient's response to treatment

## Description of Post-Service Work:

- No post - service physician work

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD				
	ASH - Samuel H. Silver, MD, PhD				
<b>Specialty(s):</b>	American Society of Hematology (ASH)				
	American Society of Clinical Oncology (ASCO)				
<b>CPT Code:</b>	+96411				
<b>Sample Size:</b>	145	<b>Resp n:</b>	35	<b>Response:</b> 24.13 %	
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.15	0.25	0.50	1.28	3.00
<b>Pre-Service Evaluation Time:</b>			5.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		

<b>Intra-Service Time:</b>		2.00	2.00	5.00	10.00	25.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>5.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10      % of respondents: 28.5 %

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: +96411	Key Reference CPT Code: <b>99211</b>
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	5.00	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	15.00	7.00

Other time if appropriate		
---------------------------	--	--

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.67	2.60
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.59	2.50
--	------	------

Urgency of medical decision making	3.31	2.45
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.43	2.63
--------------------------	------	------

Physical effort required	1.83	2.10
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.03	2.73
---	------	------

Outcome depends on the skill and judgment of physician	3.99	2.93
--	------	------

Estimated risk of malpractice suit with poor outcome	3.77	2.65
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.43	2.40
----------------------------------	------	------

Intra-Service intensity/complexity	3.76	2.58
------------------------------------	------	------

Post-Service intensity/complexity	2.99	2.24
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 3 minutes

Intra: 5 minutes RUC modified to 4 minutes

Post: 0 minutes

Total Time: 8 minutes RUC modified to 7 minutes

Consensus Panel Work Recommendation: .23RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre = 10/Intra = 15/Post = 5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre = 5/Intra = 5/Post = 10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 96401.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE FOR THIS RECOMMENDATION

CPT code +96411 is an add-on code to 96408. It was felt to deserve a lower RVU and this is reflected in the RVU value chosen. Since +96411 is billed in conjunction with 96409, there is no post-service time with this code. However, there is still some (but less) pre-service time, since dose calculations are required for the additional chemotherapeutic agent.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a fair and reasonable argument for a value of .23 RVU for CPT code +96411. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. BASE CODE: 96409; ADD-ON CODE: +96411

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) **TO BE SUBMITTED IN A SEPARATE ATTACHMENT**

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty	How often?
Specialty	How often?
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period?  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 96408.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:96413 Tracking Number: H15 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: .31

RUC RVU: 0.28

CPT Descriptor: Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: This procedure is initiated for a 64 year old woman with ovarian cancer or rheumatoid arthritis. The patient has a venous access device in place.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 13%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff
- Physician confirms and reviews any appropriate lab results as necessary
- Physician calculates dose

**Description of Intra-Service Work:**

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

**Description of Post-Service Work:**

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004
<b>Presenter(s):</b>	ACRH – Elizabeth Tindall, MD ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD AGA – Joel Brill, MD
<b>Specialty(s):</b>	American College of Rheumatology (ACR <sup>h</sup> ) American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO) American Gastroenterological Association (AGA)
<b>CPT Code:</b>	96413

<b>Sample Size:</b> 344	<b>Resp n:</b> 98	<b>Response:</b> 28.48 %			
<b>Sample Type:</b> Convenience					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.20	1.05	1.70	2.58	6.50
<b>Pre-Service Evaluation Time:</b>			10.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	2.00	5.00	10.00	20.00	240.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>10.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99214	XXX	1.10

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 25      % of respondents: 25.5 %

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 96413	Key Reference CPT Code: 99214
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	10.00	25.00
Median Immediate Post-service Time	10.00	13.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00

Median Office Visit Time	0.0	0.00
Median Total Time	30.00	38.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.21	3.81
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.15	3.77
--	------	------

Urgency of medical decision making	4.10	3.54
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.71	3.45
--------------------------	------	------

Physical effort required	3.17	3.02
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.67	3.67
---	------	------

Outcome depends on the skill and judgment of physician	4.48	3.82
--	------	------

Estimated risk of malpractice suit with poor outcome	4.45	3.63
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.15	3.40
----------------------------------	------	------

Intra-Service intensity/complexity	3.96	3.61
------------------------------------	------	------

Post-Service intensity/complexity	3.73	3.30
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA), and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 4 minutes

Intra: 7 minutes

Post: 2 minutes

Total Time: 13 minutes

Consensus Panel Work Recommendation: .31RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre=10/Intra=15/Post=5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 96401.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE FOR THIS RECOMMENDATION

This code represents up to one hour of infusion of a chemotherapeutic agent under the physician's supervision. The Intensity/Complexity Measures in the survey data reflect this increased level of service. It was felt by the Consensus Panel that the amount of physician time, work, responsibility, judgment and medical decision making exceeded that of a chest x-ray, and approached that of the intra-catheterization injection of contrast. Furthermore, there is increased interaction between the infusion nursing personnel and the physician during this service compared to 96409. The Consensus Panel further felt that the provision of a drug with the infusion justifies the increased RVU which was assigned to this code. There is an increased risk of adverse reactions for this procedure compared to 96409. The

Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a reasonable argument for a value of .31 RVU for CPT code 96413. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. BASE CODE: 96413; ADD-ON CODE: +96415, +96417

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) TO BE SUBMITTED IN A SEPARATE ATTACHMENT

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty	How often?
Specialty	How often?
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0  
 If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 96410.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: +96415 Tracking Number: H16 Global Period: ZZZ

**Recommended Work Relative Value**

Specialty Society RVU: .22

RUC RVU: 0.19

CPT Descriptor: Chemotherapy administration, intravenous infusion technique; each additional hour, one to eight (8) hours (List separately in addition to code for primary procedure)

(Use +96415 in conjunction with 96413)

(Report +96415 for infusion intervals of greater than thirty minutes beyond one hour increments)

(Report +90760 to identify hydration, or +90766 to identify nonchemotherapy drug infusion, if provided as a secondary or subsequent service in association with 96413)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A previously started infusion is continued for a 64 year old woman with ovarian cancer or rheumatoid arthritis. The patient has a venous access device in place. (This is an add-on code: the 96410 code includes the IV discontinuation, flush and discharge process.)

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 5%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- No physician pre-service work

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

## Description of Post-Service Work:

- No physician post-service work

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004
<b>Presenter(s):</b>	ACRH – Elizabeth Tindall, MD ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD AGA – Joel Brill, MD
<b>Specialty(s):</b>	American College of Rheumatology (ACR <sub>h</sub> ) American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO) American Gastroenterological Association (AGA)
<b>CPT Code:</b>	+96415

<b>Sample Size:</b> 344	<b>Resp n:</b> 93	<b>Response:</b> 27.03 %			
<b>Sample Type:</b> Convenience					
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.15	0.45	1.00	2.00	5.00
<b>Pre-Service Evaluation Time:</b>			5.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	0.00	4.00	10.00	20.00	250.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>5.00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	0.45

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 18      % of respondents: 19.3 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: +96415	Key Reference CPT Code: 99212
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	10.00	10.00
Median Immediate Post-service Time	5.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00

Median Office Visit Time	0.0	0.00
Median Total Time	20.00	15.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.51	3.25
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.39	3.20
--	------	------

Urgency of medical decision making	3.47	3.09
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.28	2.98
--------------------------	------	------

Physical effort required	2.90	2.63
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.32	3.28
---	------	------

Outcome depends on the skill and judgment of physician	4.06	3.47
--	------	------

Estimated risk of malpractice suit with poor outcome	4.20	3.32
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.43	3.03
----------------------------------	------	------

Intra-Service intensity/complexity	3.52	3.14
------------------------------------	------	------

Post-Service intensity/complexity	3.41	2.99
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## PROCESS AND PLAYERS

The American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

## CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

### Consensus Panel Time Recommendation

Pre: 0 minutes

Intra: 6 minutes RUC modified to 5 minutes

Post: 0 minutes

Total Time: 6 minutes RUC modified to 5 minutes

Consensus Panel Work Recommendation: .22 RVU

## CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 96411.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre = 10/Intra = 15/Post = 5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre = 5/Intra = 5/Post = 10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 96401.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

## EVIDENCE FOR THIS RECOMMENDATION

This code describes the continuation of the infusion of a chemotherapy drug beyond the first hour. CPT code +96415 is designated as an add-on code to 96413, and thus the pre- and post-service work is captured in the initial code. There is a risk of adverse reactions for this procedure. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.



Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No  
If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 96412.  
Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:96416 Tracking Number: H17 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: .24

RUC RVU: 0.21

CPT Descriptor: Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump

(For insertion of pump, use 36563)

(For refilling and maintenance of a portable pump or an implantable infusion pump or reservoir for drug delivery, see 96521, 96523, 96522)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 58 year old female having periodic prolonged infusions of fluorouracil presents for her therapy.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff
- Physician confirms and reviews any appropriate lab results as necessary
- Physician calculates dose

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

## Description of Post-Service Work:

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004		
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD		
<b>Specialty(s):</b>	American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO)		
<b>CPT Code:</b>	96416		
<b>Sample Size:</b>	145	<b>Resp n:</b>	33
		<b>Response:</b>	%

Sample Type: Convenience					
	Low	25 <sup>th</sup> pctl	Median*	75th pctl	High
Survey RVW:	0.17	0.33	0.70	1.25	7.00
Pre-Service Evaluation Time:			10.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	2.00	5.00	10.00	20.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
Immed. Post-time:	<u>10.00</u>				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	0.45

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 6      % of respondents: 18.1 %**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 96416</u>	<u>Key Reference CPT Code: 99212</u>
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	10.00	10.00
Median Immediate Post-service Time	10.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00

Median Office Visit Time	0.0	0.00
Median Total Time	30.00	15.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.06	3.18
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.94	3.19
--	------	------

Urgency of medical decision making	3.73	2.94
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.79	2.88
--------------------------	------	------

Physical effort required	2.76	2.39
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.48	3.13
---	------	------

Outcome depends on the skill and judgment of physician	4.36	3.30
--	------	------

Estimated risk of malpractice suit with poor outcome	4.03	2.97
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.12	2.94
----------------------------------	------	------

Intra-Service intensity/complexity	3.69	3.00
------------------------------------	------	------

Post-Service intensity/complexity	3.79	2.79
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

PROCESS AND PLAYERS

The American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 4minutes

Intra: 4 minutes

Post: 2 minutes

Total Time: 10 minutes

Consensus Panel Work Recommendation: .24 RVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination. (Pre=10/Intra=15/Post=5)		.23
76076	Dual energy x-ray absorptiometry (DEXA) (Pre=5/Intra=5/Post=10)		.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 96401.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE FOR THIS RECOMMENDATION

This code describes initiation of prolonged chemotherapy infusion, requiring use of a portable pump. The interactions with nursing personnel are decreased as compared to 96413, and the surveyed mental effort and judgment was not as intense as 96413. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.



Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 96414.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: +96417 Tracking Number: H18 Global Period: ZZZ

**Recommended Work Relative Value**

Specialty Society RVU: .24

RUC RVU: 0.21

CPT Descriptor: Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to one hour (List separately in addition to code for primary procedure)  
(Use +96417 in conjunction with code 96413; report only once per sequential infusion; report +96415 for additional hour(s) of sequential infusion)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 64 year old female with ovarian cancer presents for infusion. She has completed infusion of one chemotherapy drug and is now infused with a second drug through her implanted venous access device. (This is an add-on code: the 96413 code includes the IV discontinuation, flush and discharge process.)

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 6%

Is conscious sedation inherent in your reference code? Yes

## Description of Pre-Service Work:

- Physician confirms orders
- Physician conducts reassessment of patient status prior to commencing new drug infusion
- Physician calculates dose

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician periodically assesses patient and patient's response to treatment, typically through communication with the nurse

## Description of Post-Service Work:

- No physician post-service work

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD				
<b>Specialty(s):</b>	ASH - Samuel H. Silver, MD, PhD American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO)				
<b>CPT Code:</b>	+96417				
<b>Sample Size:</b>	145	<b>Resp n:</b>	32	<b>Response:</b>	22.06 %
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.13	0.40	0.90	1.14	6.50
<b>Pre-Service Evaluation Time:</b>			6.0		
<b>Pre-Service Positioning Time:</b>			0.0		

Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		1.00	3.00	5.00	12.75	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
Immed. Post-time:	<u>5.00</u>					
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	0.45

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8      % of respondents: 25.0 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: +96417	Key Reference CPT Code: <u>99211</u>
Median Pre-Service Time	6.00	0.00
Median Intra-Service Time	5.00	5.00
Median Immediate Post-service Time	5.00	2.00
Median Critical Care Time	0.0	0.00

Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	16.00	7.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.72	2.97
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.69	2.84
--	------	------

Urgency of medical decision making	3.62	2.66
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.45	2.71
--------------------------	------	------

Physical effort required	2.58	2.29
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.13	2.52
---	------	------

Outcome depends on the skill and judgment of physician	3.94	2.81
--	------	------

Estimated risk of malpractice suit with poor outcome	3.81	2.59
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.66	2.66
----------------------------------	------	------

Intra-Service intensity/complexity	3.50	2.81
------------------------------------	------	------

Post-Service intensity/complexity	3.44	2.44
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

## PROCESS AND PLAYERS

The American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

## CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

### Consensus Panel Time Recommendation

Pre: 2 minutes

Intra: 7 minutes RUC modified to 6 minutes

Post: 0 minutes

Total Time: 9 minutes RUC modified to 8 minutes

Consensus Panel Work Recommendation: .24 WRVU

## CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90780X1, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre = 10/Intra = 15/Post = 5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre = 5/Intra = 5/Post = 10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 96401.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

## EVIDENCE FOR THIS RECOMMENDATION

This code describes the sequential infusion of a drug after the initial 96413 service. The physician work for this infusion parallels that of 96413, however the pre-service work is less (but chemotherapy dosing still requires recalculation), and the post-service work is accounted for in the 96413 code which this code is an add on to. There is a risk of adverse reactions for this procedure.



Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 96412.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:96521 Tracking Number: H24 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: .24

RUC RVU: 0.21

CPT Descriptor: Refilling and maintenance of portable pump

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 58 year old female having a prolonged infusions of fluorouracil presents to have her portable infusion pump refilled.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff
- Physician confirms and reviews any lab results as necessary
- Physician calculates dose

## Description of Intra-Service Work:

- Physician provides direct supervision and is immediately available in office
- Physician assesses patient's response to treatment

## Description of Post-Service Work:

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		09/2004			
Presenter(s):	ASCO - David Regan, MD & W. Charles Penley, MD				
Specialty(s):	American Society of Clinical Oncology (ASCO)				
CPT Code:	96521				
Sample Size:	86	Resp n:	21	Response: 24.41 %	
Sample Type:	Convenience				
	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW:	0.15	0.31	1.00	1.10	4.50
Pre-Service Evaluation Time:			7.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	0.00	5.00	5.00	12.00	40.00
Post-Service	Total Min**	CPT code / # of visits			

<b>Immed. Post-time:</b>	<u>5.00</u>	
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0 99292x 0.0
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0 99232x 0.0 99233x 0.0
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00 99239x 0.00
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	0.45

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	.17

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99212	XXX	.45

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6      % of respondents: 28.5 %

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 96521</u>	<u>Key Reference CPT Code: 99212</u>
Median Pre-Service Time	7.00	0.00
Median Intra-Service Time	5.00	10.00
Median Immediate Post-service Time	5.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00

Median Office Visit Time	0.0	0.00
Median Total Time	17.00	15.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.43	2.57
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	2.62
--	------	------

Urgency of medical decision making	3.43	2.57
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.38	2.33
--------------------------	------	------

Physical effort required	2.67	1.86
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.14	2.52
---	------	------

Outcome depends on the skill and judgment of physician	3.76	2.67
--	------	------

Estimated risk of malpractice suit with poor outcome	3.86	2.76
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.48	2.33
----------------------------------	------	------

Intra-Service intensity/complexity	3.14	2.67
------------------------------------	------	------

Post-Service intensity/complexity	3.48	2.43
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO) conducted an on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sub>h</sub>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America and the American Urological Association (AUA).

#### CONSENSUS PANEL RECOMMENDATIONS

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

##### Consensus Panel Time Recommendation

Pre: 4 minutes

Intra: 4 minutes

Post: 2 minutes

Total Time: 10 minutes

Consensus Panel Work Recommendation: .24 WRVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre = 10/Intra = 15/Post = 5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre = 5/Intra = 5/Post = 10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 96401.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE FOR THIS RECOMMENDATION

This code describes refilling and maintenance of portable pump for chemotherapy infusion. The work, mental effort, and risk of this code are identical to 96416. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a reasonable argument for a value of .24 RVU for CPT code 96521. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) **TO BE SUBMITTED IN A SEPARATE ATTACHMENT**

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

- Specialty \_\_\_\_\_ How often?
- Specialty \_\_\_\_\_ How often?
- Specialty \_\_\_\_\_ How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

- Specialty \_\_\_\_\_ Frequency 0 Percentage 0.00 %
- Specialty \_\_\_\_\_ Frequency 0 Percentage 0.00 %
- Specialty \_\_\_\_\_ Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

- Specialty \_\_\_\_\_ Frequency 0 Percentage 0.00 %
- Specialty \_\_\_\_\_ Frequency 0 Percentage 0.00 %

Specialty

Frequency 0

Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 96520.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

**Recommended Work Relative Value**

CPT Code:96522 Tracking Number: H26 Global Period: XXX Specialty Society RVU: .24 RUC RVU: 0.21

CPT Descriptor: Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)

(For refilling and maintenance of an implantable infusion pump for spinal or brain drug infusion, use 95990)

(For collection of blood specimen from a completely implantable venous access device, use 36540)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: The procedure is initiated for a 66 year old male patient with metastatic colorectal carcinoma with disease limited to the liver. A hepatic artery catheter has previously been placed by a surgeon, with an attached implanted pump (e.g. Infusaid pump). The pump is refilled.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Physician provides and confirms orders
- Physician interacts and reviews plan with staff
- Physician confirms and reviews lab results as necessary

**Description of Intra-Service Work:**

- Physician provides direct supervision and is immediately available in office
- Physician calculates and recalculates dosage and infusion rate

**Description of Post-Service Work:**

- Physician provides appropriate instructions regarding immediate care
- Physician provides minimal instructions regarding ongoing care
- Physician conducts appropriate interactions with staff regarding patient monitoring

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004				
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD ASH - Samuel H. Silver, MD, PhD				
<b>Specialty(s):</b>	American Society of Hematology (ASH) American Society of Clinical Oncology (ASCO)				
<b>CPT Code:</b>	96522				
<b>Sample Size:</b>	145	<b>Resp n:</b>	17	<b>Response:</b>	11.72 %
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.30	0.71	1.08	1.49	6.00

<b>Pre-Service Evaluation Time:</b>				<b>10.0</b>		
<b>Pre-Service Positioning Time:</b>				<b>0.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		4.00	5.00	<b>12.00</b>	20.00	45.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b><u>5.00</u></b>					
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99231	XXX	0.64

CPT Descriptor Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4      % of respondents: 23.5 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 96522	Key Reference CPT Code: <u>99231</u>
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	12.00	15.00
Median Immediate Post-service Time	5.00	4.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	27.00	19.00

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.71	2.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.88	3.18
Urgency of medical decision making	3.53	2.94

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	3.00
--------------------------	------	------

Physical effort required	3.24	2.65
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.35	3.18
---	------	------

Outcome depends on the skill and judgment of physician	3.94	3.35
--	------	------

Estimated risk of malpractice suit with poor outcome	3.71	2.94
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.06	2.94
----------------------------------	------	------

Intra-Service intensity/complexity	3.59	3.06
------------------------------------	------	------

Post-Service intensity/complexity	3.41	2.76
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) conducted a joint on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sup>h</sup>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

**CONSENSUS PANEL RECOMMENDATIONS**

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

**Consensus Panel Time Recommendation**

Pre: 4 minutes

Intra: 4 minutes

Post: 2 minutes

Total Time: 10 minutes

Consensus Panel Work Recommendation: .24 WRVU

#### CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96400 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre = 10/Intra = 15/Post = 5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre = 5/Intra = 5/Post = 10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 96401.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE FOR THIS RECOMMENDATION

This code describes refilling and maintenance of implantable pump or reservoir for chemotherapy drug delivery. The work, mental effort, and risk of this code are identical to 96416. The Consensus Panel discussed that physician work for this procedure involves dealing with the diagnosis and management of minor reactions that can occur but do not rise to the level of a separately billable EM encounter.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a reasonable argument for a value of .24 RVU for CPT code 96522. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) **TO BE SUBMITTED IN A SEPARATE ATTACHMENT**

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty	How often?
Specialty	How often?
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0  
 If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No  
 If no, please select another crosswalk and provide a brief rationale. Recommend crosswalk to former code 96530.  
 Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

**Recommended Work Relative Value**

CPT Code:96523 Tracking Number: H25 Global Period: XXX Specialty Society RVU: 0.04 RUC RVU: .04

CPT Descriptor: Irrigation of implanted venous access device for drug delivery systems  
(Do not report 96523 if an injection or infusion is provided on the same day

)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 72 year old male with lung carcinoma has an implanted venous access device for drug delivery and returns to the clinic for flushing and maintenance of the device on a day when chemotherapy or other treatments are not planned.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Physician provides orders

Description of Intra-Service Work:

- No physician intra-service work

Description of Post-Service Work:

- No Physician post-service work

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>	ASCO - David Regan, MD & W. Charles Penley, MD				
<b>Specialty(s):</b>	American Society of Clinical Oncology (ASCO)				
<b>CPT Code:</b>	96523				
<b>Sample Size:</b>	86	<b>Resp n:</b>	23	<b>Response:</b> 26.74 %	
<b>Sample Type:</b>	Convenience				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.00	0.16	0.25	0.43	2.50
<b>Pre-Service Evaluation Time:</b>			2.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	0.00	1.50	3.00	5.00	15.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	<u>1.00</u>	
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00 99239x 0.00
Office time/visit(s):	<u>0.0</u>	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
99211	XXX	0.17

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11      % of respondents: 47.8 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 96523	Key Reference CPT Code: 99211
Median Pre-Service Time	2.00	0.00
Median Intra-Service Time	3.00	5.00
Median Immediate Post-service Time	1.00	2.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	6.00	7.00

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	1.73	1.91
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.70	1.74
Urgency of medical decision making	1.70	1.74

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.62	1.82
Physical effort required	1.71	1.50

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.57	1.91
Outcome depends on the skill and judgment of physician	2.04	2.04
Estimated risk of malpractice suit with poor outcome	2.35	2.00

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	1.78	1.78
Intra-Service intensity/complexity	2.04	1.91
Post-Service intensity/complexity	1.65	1.73

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**PROCESS AND PLAYERS**

The American Society of Clinical Oncology (ASCO) conducted an on-line survey. Physician advisors and staff met in-person to review the data and develop practice expense recommendations.

Due to concerns about limitations of the data, a consensus panel was convened to develop the RUC recommendations. This panel was composed of physician advisors from the American College of Rheumatology (ACR<sup>h</sup>), American Gastroenterological Association (AGA), American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), Infectious Diseases Society of America (IDSA) and the American Urological Association (AUA).

**CONSENSUS PANEL RECOMMENDATIONS**

The panel reviewed the data from the on-line survey and discussed their personal experience with this code. The panel unanimously made the following physician time and work recommendations:

**Consensus Panel Time Recommendation**

Pre: 2 minutes

Intra: 0 minutes

Post: 0 minutes

Total Time: 2 minutes

Consensus Panel Work Recommendation: .04 WRVU

**CONSENSUS PANEL RATIONALE - CROSSWALK EXPLANATION**

The Consensus Panel first determined a value for the base code in the family, CPT code 96401.

In reviewing the survey data for the 96401 series, the panel was struck by the increased physician work involved with these procedures in comparison to the 90760 series. In comparison to the 90760 series the 96401 family of codes is typically associated with greater intensity of service due to the greater toxicity of the agents administered and the higher frequency of acute adverse events during the intra-service period. The 96401 series of codes is typically associated with greater pre-service time requirements due to the fact that each drug is dosed individually for a given patient, with often complex calculations being required for each agent.

Taking this into consideration, the Panel agreed that .21 was a reasonable value. This is an increase of .04 RVU to CPT code 90760, base code of 90760 series (Rationale to be found in Work Summary Recommendation forms for 90760 series).

To test the reasonableness of this value the Consensus Panel compared it to other RUC-surveyed CPT codes.

CODE	DESCRIPTOR	TIME	RVU
58323	Sperm washing for artificial insemination.	(Pre=10/Intra=15/Post=5)	.23
76076	Dual energy x-ray absorptiometry (DEXA)	(Pre=5/Intra=5/Post=10)	.22

After reviewing these comparisons, the Consensus Panel was very comfortable recommending a value of .21 for CPT code 96401.

Once the Workgroup agreed to the value of .21 for 96401, the remaining codes in the family were discussed relative to this value.

#### EVIDENCE FOR THIS RECOMMENDATION

This code describes irrigation of an implanted venous access device for chemotherapy drug delivery systems. There is only 2 minutes of pre-service time.

The Consensus Panel, composed of physicians from multiple specialties, concluded that they had made a reasonable argument for a value of .04 RVU for CPT code 96523. This value maintains rank order within the other recommendations submitted by the Infusion Workgroup as well as within the universe of all RUC codes.

#### SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.



DRUG ADMINISTRATION  
PLI CROSSWALKS

CPT Code RUC ID Crosswalk to Code: PLI RVU in Proposed Rule

90760 H1	90780	0.07
90761 H2	90781	0.04
90765 H3	90780	0.07
90766 H5	90781	0.04
90767 H4	90781	0.04
90768 H6	90781	0.04
90772 H7	90782	0.01
90774 H9	90784	0.04
90775 H10	90781	0.04
96401 H11	96408	0.06
96402 H12	96408	0.06
96409 H13	96408	0.06
96411 H14	96408	0.06
96413 H15	96410	0.08
96415 H16	96412	0.07
96416 H17	96414	0.08
96417 H18	96412	0.07
96521 H24	96520	0.06
96522 H26	96530	0.06
96523 H25	96520	0.06

Oct-04

AMA/Specialty Society RVS Update Committee  
 Summary of Recommendations  
 February 2004

***Pediatric-Specific Immunization Administration***

The CPT Editorial Panel has created four new pediatric immunization administration codes to identify these services when provided to patients under eight years of age. In addition to differentiating these services from the existing CPT codes 90471 – 90474, which also describe immunization administration, the Panel editorially revised these codes to exclude “jet injections.” The clinical vignettes for these existing services have been revised to describe patients older than eight years of age.

The RUC has reviewed immunization administration on multiple occasions, including our May 1999 and February 2001 meetings. In addition, the RUC has submitted formal comments to CMS requesting the publication of work relative value units for these services. We have attached our prior recommendations and comments to this submission and reiterate our position that there is indeed physician work involved in the administration of vaccines. The RUC has reviewed the new CPT codes 90465-90468 for immunization administration provided to children under eight years of age and recommends that the RUC’s previous recommendations for physician work, time, and direct practice expense inputs be adopted for these new services. **The recommended work relative values and physician time elements are as follows:**

<u>CPT Code</u>	<u>Descriptor</u>	<u>Work RVU</u>	<u>Intra-Time</u>	<u>Crosswalked from Code</u>
90465	<b>Immunization administration under 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; first injection (single or combination vaccine/toxoid), per day</b>	0.17	7	90471
90466	<b>each additional vaccine</b>	0.15	7	90472
90467	<b>Immunization administration under age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/toxoid), per day</b>	0.17	7	90473
90468	<b>each additional vaccine</b>	0.15	7	90474

Practice Expense

The direct practice expense for these new codes are crosswalked from the existing codes, which have been through the refinement process in February 2001 and March 2002 at the Practice Expense Advisory Committee (PEAC) meetings. The recommended practice expense direct inputs for the new codes are attached to this recommendation.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Codes 90471-90474, 90468 must be reported in addition to the vaccine and toxoid code(s) 90476-90749.</p> <p><u>Report codes 90465-90468 only when the physician provides face-to-face counseling of the patient and family during the administration of a vaccine. For immunization administration of any vaccine that is not accompanied by face-to-face physician counseling to the patient/family, report codes 90471-90474.</u></p> <p><i>If a significant separately identifiable Evaluation and management...</i>  <i>(For allergy testing, see 95004 et seq)</i>  <i>(For skin testing of bacterial, viral, fungal extracts, see 86485-86586)</i>  <i>(For therapeutic or diagnostic injections, see 901782-90799)</i></p>				
●90465	N5	Immunization administration under 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; first injection (single or combination vaccine/toxoid), per day  <u>(Do not report 90465 in conjunction with 90467)</u>	XXX	0.17
+●90466	N6	each additional injection (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure) <u>(Use 90466 in conjunction with 90465 or 90467)</u>	ZZZ	0.15

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●90467	N7	Immunization administration under age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/toxoid), per day  (Do not report 90467 in conjunction with 90465)	XXX	0.17
+●90468	N8	each additional administration (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure)  (Use 90468 in conjunction with 90465 or 90467)	ZZZ	0.15
▲90471	N1	Immunization administration (includes percutaneous, intradermal, subcutaneous, and intramuscular <del>and jet injections</del> ); one vaccine (single or combination vaccine/toxoid)  (Do not report 90471 in conjunction with 90473)	XXX	0.17  (Previous RUC Recommendation)
▲+90472	N2	each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)  (Use 90472 in conjunction with 90471 or 90473)(For administration of immune globulins, use 90780-90784, and see 90281-90399)  (For intravesical administration of BCG vaccine, use 51720, and see 90586)	ZZZ	0.15  (Previous RUC Recommendation)
90473	N3	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid) (Do not report 90473 in conjunction with 90471)	XXX	0.17  (Previous RUC Recommendation)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
+90474	N4	each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)  (Use 90474 in conjunction with <u>90471</u> or 90473)	ZZZ	0.15  (Previous RUC Recommendation)

9047X1-9047X4 January 2004 RUC		90465		90466		90467		90468	
DIRECT PE INPUTS AS APPROVED BY THE PEAC (MARCH 2002) AND THE RUC (FEBRUARY 2001) FOR CODES 90471-90474		Immunization administration (percutaneous, intradermal, subcutaneous, intramuscular) under age 8 years when physician counsels the patient/family; first injection		each additional injection		Immunization administration (oral/intranasal) under age 8 years when physician counsels the patient/family; first administration		each additional administration	
LOCATION	HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
GLOBAL PERIOD		XXX	XXX	ZZZ	ZZZ	XXX	XXX	XXX	ZZZ
TOTAL CLINICAL LABOR TIME	L042A (RN/LPN)	13	3	7	0	13	3	7	0
<b>PRE-SERVICE</b>									
Start: Following visit when decision for surgery or procedure made									
Complete pre-service diagnostic & referral forms									
Coordinate pre-surgery services									
Office visit before surgery/procedure: Review test and exam results									
Provide pre-service education/obtain consent									
Follow-up phone calls & prescriptions									
Other Clinical Activity (please specify)									
End: When patient enters office for surgery/procedure									
<b>SERVICE PERIOD</b>									
Start: When patient enters office for surgery/procedure									
Pre-service services									
Review charts	L042A	1	0	0	0	1	0	0	0
Greet patient and provide gowning									
Obtain vital signs									
Provide pre-service education/obtain consent									
Prepare room, equipment, supplies									
Prepare and position patient/ monitor patient/ set up IV									
Sedate/apply anesthesia									
F/u on physician's discussion w/patient/parent & obtain actual consent signature	L042A	3	0	3	0	3	0	3	0
<b>Intra-service</b>									
Assist physician in performing procedure									
Draw up serum; administer vaccine	L042A	2	0	2	0	2	0	2	0
<b>Post-Service</b>									
Monitor pt. following service/check tubes, monitors, drains	L042A	3	0	0	0	3	0	0	0
Clean room/equipment by physician staff	L042A	1	0	0	0	1	0	0	0
Complete diagnostic forms, lab & X-ray requisitions									
Review/read X-ray, lab, and pathology reports									
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L042A	1	0	0	0	1	0	0	0
Other Clinical Activity (please specify): record vaccine information (lot number, manufacturer, VIS information)	L042A	2	0	2	0	2	0	2	0
End: Patient leaves office									
<b>POST-SERVICE Period</b>									
Start: Patient leaves office									
Conduct phone calls/call in prescriptions									
Follow-up to ensure that patient's medical record reflects immunizations given, thereby ensuring continuity of care in the medical home	L042A	0	3	0	0	0	3	0	0
Total Office Visit Time									
Conduct phone calls between office visits		#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
Other Activity (please specify)									
End: with last office visit before end of global period									

DIRECT PE INPUTS AS APPROVED BY THE PEAC (MARCH 2002) AND THE RUC (FEBRUARY 2001) FOR CODES 90471-90474		90465		90466		90467		90468	
HCFA STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE		Immunization administration (percutaneous, intradermal, subcutaneous, intramuscular) under age 8 years when physician counsels the patient/family; first injection		each additional injection		Immunization administration (oral/intranasal) under age 8 years when physician counsels the patient/family; first administration		each additional administration	
LOCATION		In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
<b>MEDICAL SUPPLIES</b>									
CDC information sheet	SK012	1	N/A	1	N/A	1	N/A	1	N/A
exam table paper, one foot	SB036	7	N/A	N/A	N/A	7	N/A	N/A	N/A
gloves, non-sterile	SB022	1	N/A	N/A	N/A	1	N/A	N/A	N/A
swab, alcohol	SJ053	2	N/A	2	N/A	N/A	N/A	N/A	N/A
band-aid, 0.75 in x 3 in	SG021	1	N/A	1	N/A	N/A	N/A	N/A	N/A
Syringe w-needle, OSHA compliant (SafetyGlide)	SC058	1	N/A	1	N/A	N/A	N/A	N/A	N/A
<b>EQUIPMENT</b>									
Exam table	E11001	X	N/A	X	N/A	X	N/A	X	N/A

## RUC Comment Letters – Excerpts on Immunization Administration

### ***Comment on the 2003 MFS Final Rule:***

The RUC joins many others who will comment that CMS should be applauded for addressing the overall payment for immunization administration via a significant increase to the practice expense relative values. We are pleased that the CMS has accepted the RUC's recommendations for the direct practice expense inputs for these codes.

The RUC has commented on the issue of assigning physician work relative values for immunization administration repeatedly over the past few years. The RUC firmly believes that although the nurse may administer the vaccine and often addresses questions posed by the patient/parent, this is in follow-up to the physician's discussion with the patient/parent.

As the RUC has indicated in the past, the physician does discuss with the patient/parent the benefits and risks related to the vaccine(s). These interactions are similar to other services where CMS has acknowledged, through acceptance of RUC recommendations, that a nurse may follow-up or repeat earlier discussions that the patient has had with the physician. The RUC concluded that the physician work involved in immunization administration was comparable to the work involved in 99211 (*see Evaluation & Management, established Patient*) which has a work RVU of 0.17. **We continue to strongly urge you to publish work relative values of 0.17 and 0.15 for CPT codes 90471 and 90472, respectively. The RUC also offers to collect additional data regarding the physician involvement in these services, if CMS indicates that this data may be useful in reconsidering this issue.**

The RUC also urges CMS to eliminate the G codes that are duplicative of the CPT codes that may be used for the administration of Medicare covered vaccines.

### ***Comment on the 2003 MFS Proposed Rule:***

We are pleased that you have proposed to accept our direct practice expense input recommendations for CPT codes 90471 and 90472 *Immunization Administration*. The PEAC and RUC carefully reviewed these codes again this spring and agreed that these inputs represent fairly the nursing time and supply expense required to perform these important services. The NPRM was not specific regarding the updated data submitted to CMS in May 2002. We have, therefore, re-submitted the RUC's recommendations for these codes as an attachment to this letter.

The RUC urges you to reconsider your decision to not publish physician work relative values for these services. In the NPRM, you state that "We have not assigned immunization administration physician work RVUs because this service does not typically involve a physician. The nurse that administers the vaccine typically provides the necessary counseling to the patient and this time is accounted for in the practice expense RVU." In our practice expense recommendations, the RUC indicates that the

nurse does discuss the vaccines with the patient and obtains the actual consent signature. However, we specifically noted that this is in follow-up to the physician's discussion with the patient/parent. As the RUC has indicated in the past, the physician does discuss with the patient/parent the benefits and risks related to the vaccine(s). These interactions are similar to other services where CMS has acknowledged, through acceptance of RUC recommendations, that a nurse may follow-up or repeat earlier discussions that the patient has had with the physician. The RUC concluded that the physician work involved in immunization administration was comparable to the work involved in 99211 (*see Evaluation & Management, established Patient*) which has a work RVU of 0.17. **We strongly urge you to publish work relative values of 0.17 and 0.15 for CPT codes 90471 and 90472, respectively.**

***Comment on the 2001 MFS Final Rule:***

On several occasions, the RUC has recommended to CMS that CPT codes 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); one vaccine (single or combination vaccine/toxoid)* and 90472 *each additional vaccine* require physician involvement and should have assigned work relative value units of 0.17 and 0.15, respectively. In February 2001, the RUC again submitted recommendations for 90471 and 90472, along with work relative values of 0.17 and 0.15 for the new immunization administration by intranasal or oral route codes (90473 and 90474) that mirror the injection codes.

CMS continues to argue that these services are performed by a nurse and require no physician work. Ironically, on the same page (55308) of the November 1, 2001 *Federal Register* where this argument is presented, CMS announces that it will ignore a RUC recommendation that CPT code 93701 *Bioimpedence, thoracic, electrical* should be assigned zero work values, and instead implements a work value of 0.17. The RUC would ask that CMS more seriously consider the input of our multi-specialty committee of practicing physicians regarding the very basic decision on whether a physician is involved in the provision of a service to a patient.

The RUC had considered that physicians must counsel patients/parents about the risks and benefits of any immunization, and agreed that this work is not captured in any existing codes that may, or may not, be reported on the same date as the immunization. The American Academy of Pediatrics has presented information that physicians are required, under the National Childhood Vaccine Injury Act and the Center for Disease Control's Vaccines for Children Program, to explain the benefits to the patient and the community, as well as the possibilities of adverse reactions to vaccines. We do not understand why CMS remains unconvinced by this evidence, but we strongly urge you to reconsider and publish work relative values for these immunization administration codes.

***Comments on the 2001 MFS Proposed Rule:***

In May 1999, the RUC forwarded recommendations on the work relative values and direct practice expense inputs for CPT codes 90471 and 90472 *Immunization*

*Administration.* The November 2, 1999 Final Rule omitted any relative values for CPT codes 90471 and 90472 in Addendum B, however, the text of the Rule included a discussion (page 59425) that HCFA adopted the RUC's practice expense inputs for these services with few modifications. Unlike every other RUC work RVU recommendation that was listed on Table 2 of page 59418, the work RVUs for these codes were completely ignored. The RUC and the American Academy of Pediatrics had informed HCFA of this discrepancy in their comments on the Final Rule.

We note in Addendum B in the July 17, 2000 Proposed Rule that you have again failed to publish relative values for codes 90471 and 90472. While HCFA may choose not to reimburse these services under the Medicare program, the RUC encourages HCFA to still publish relative values for these codes. This is similar to how the pediatric preventive visit codes 99381-99384 are treated by HCFA, despite the fact that they are not reimbursed under the Medicare program, their relative values are still published. The RUC encourages HCFA to take the same stance with the vaccine administration codes, and to publish the recommendations forwarded by the RUC. It is important that relative values for these immunization codes are published in order to provide guidance to other payers, such as Medicaid and private payers, who are increasingly utilizing the RBRVS physician payment schedule.

HCFA must understand that it has responsibility for a payment system that reaches beyond Medicare. Your lack of publication of relative value units for any services has ramifications that we believe you fail to consider. The RUC has heard anecdotal reports that some payors that were previously providing payment for these services have since ceased payment as "Medicare does not publish relative values for the codes." We realize that HCFA staff resources are limited, and that you will largely focus your efforts on issues that effect the Medicare population. This issue, however, could be resolved expeditiously by accepting the modest RUC recommendations for physician work and publishing the practice expense work RVUs that result based on the direct inputs that you listed in the text of the November 2, 1999 Final Rule.

***Comment Letter on the 2000 MFS Final Rule:***

The Final Rule omitted any relative values for CPT codes 90471 and 90472 and only the practice expense inputs were discussed in the Rule. The RUC recommended work relative values as well as direct inputs for these two codes. While HCFA may choose not to reimburse these services under the Medicare program, the RUC encourages HCFA to still publish relative values for these codes. This is similar to how the pediatric preventive visit codes 99381-99384 are treated by HCFA, despite the fact that they are not reimbursed under the Medicare program, their relative values are still published. The RUC encourages HCFA to take the same stance with the vaccine administration codes, and to publish the recommendations forwarded by the RUC. It is important that values to these codes are published in order to provide guidance to other payers, such as Medicaid and private payers, who are increasingly utilizing the RBRVS physician fee schedule.

**AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE**  
**SUMMARY OF RECOMMENDATIONS**  
**May 1999**

**IMMUNIZATION ADMINISTRATION**

***Work Relative Value Recommendations***

Code 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); one vaccine (single or combination vaccine/toxoid)*, and code 90472 *Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); each additional vaccine (single or combination vaccine/toxoid)* were both editorially revised to more accurately reflect the work associated with administering vaccines. These changes were made so that the resources and work required to administer multiple vaccines would be more accurately identified and also to more accurately track the costs of administering immunizations.

While the specialty presented its median survey RVW as the recommended RVW, the RUC reviewed this recommendation and concluded that the RVW was too high since immunization administration is typically performed in conjunction with a evaluation and management code. The RUC concluded that the work involved in immunization administration was comparable to the work involved in 99211 (*see Evaluation & Management, established Patient*) which has a work RVU of 0.17. To maintain the originally proposed relativity between the administration of the first vaccine and each additional vaccine (which was .02 RVW's lower), the RUC recommended reducing 90472 by .02 RVUs, for a final recommended RVU of .15. The RUC therefore recommends a work RVU recommendation of .17 for code 90471 and an RVU of .15 for code 90472.

***Practice Expense Recommendations***

*CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.*

The RUC examined the direct inputs associated with immunization administration and added “ Xerox copy” as an additional supply item to both 90471 and 90472 to reflect the cost of documenting the immunization for public health purposes. The RUC discussed the marginal costs involved in code 90472 and agreed to reduce the clinical staff time to two minutes. The RUC decided that the time to provide an additional immunization was only two minutes, substantially lower than the time required to provide the first immunization.

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
90471	CC1	Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); <u>one vaccine</u> (single or combination vaccine/toxoid)	XXX	.17
σ90472	CC2	<del>two or more</del> <u>each additional vaccine</u> (single or combination vaccine/toxoid)  (List 90472 in conjunction with 90471)	ZZZ	.15

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE  
SUMMARY OF RECOMMENDATIONS  
February 2001

**Immunization (Two or More Injections)**

The RUC approved a recommendation from pediatrics that the new codes to describe intranasal or oral administration of vaccines should be assigned the same work relative value as the existing CPT codes for immunization administration as outlined in the attached letter. **The RUC recommends a work relative value of .17 for code 90473 and .15 for code 90474.**

The RUC also recommends that the direct practice expense inputs should be the same for these codes, with an exclusion of a band-aid (1), a syringe (1), and needles (2) on the medical supply list for codes 90473 and 90474.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
σ90471	B1	Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections <del>and/or intranasal or oral administration</del> ); one vaccine (single or combination vaccine/toxoid)	XXX	.17  (previously accepted by RUC)
σ:90472	B2	each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)  (Use 90472 in conjunction with code 90471)	ZZZ	.15  (previously accepted by RUC)
●90473	B3	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)	XXX	.17
:●90474	B4	each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)  (Use 90474 in conjunction with code 90473)	ZZZ	.15

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF WORK RECOMMENDATION

(April 1999)

Recommended RVW: 0.20

CPT Code/ Tracking: 90471 (CC1)

Global Period: XXX

**CPT Descriptor:** Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); one vaccine (single or combination vaccine/toxoid)

**Vignette Used in Survey:**

An 18-month old girl is seen for a well-child visit. In accordance with national recommendations for childhood immunizations, the pediatrician determines that the child should receive a diphtheria, tetanus, and pertussis (DTaP) vaccination. The parent is asked whether the child has had any reactions to previous DTaP immunizations and is given a vaccine information sheet on DTaP. The physician reviews the benefits and risks of providing the DTaP vaccination with the parent. The child is given the DTaP immunization as an injection. A dose of acetaminophen is given to the child at the office to reduce the incidence and severity of fever and irritability from the DTaP immunization. The immunization tracking number is entered into a computerized statewide registry.

**CLINICAL DESCRIPTION OF SERVICE** (This work description was NOT provided on the survey.):

**Description of Total Work:**

The physician discusses with the patient/parent/guardian the benefits and risks for a necessary/required vaccine/toxoid administration. If the vaccine/toxoid has been administered previously, the patient/parent/guardian is questioned about previous reactions. Available pertinent informational material is provided to the patient/parent/guardian. The vaccine/toxoid is administered, along with a dose of acetaminophen, if appropriate. The immunization tracking number is entered into a computerized statewide registry.

**SURVEY DATA:**

**Presenter(s):** Steven Krug, MD

**Specialty(s):** American Academy of Pediatrics

**Sample Size:** 180      **Response Rate (No. and %):** 35 (19.4%)

**Type of Sample** (✓ one):    ~~random~~      ✓ panel      ~~convenience~~

**Survey RVW**                      **Low:** 0.10      **25th%:** 0.18      **Med:** 0.20      **75th%:** 0.45      **High:** 1.10

**Survey Total Time**              **Low:** 2      **25th%:** 5      **Med:** 7      **75th%:** 10      **High:** 25

**KEY REFERENCE SERVICE(S):**

<u>1999 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
0.17	XXX	94010	Spirometry, including graphic record, total and times vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
0.45	XXX	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 patients and/or family 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.

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

	<i>Mean</i> Intensity/Complexity Measures		
	90471	94010	99212
<b>Time Estimates (Median)</b>			
PRE-service time	n/a	n/a	n/a
INTRA-service time (TOTAL time for XXX global)	7	7	10
POST-service time	n/a	n/a	n/a
<b>Mental Effort and Judgment</b>			
The number of possible diagnosis and/or the number of management options that must be considered	2.34	2.29	2.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained reviewed and analyzed	2.63	2.43	2.80
Urgency of medical decision making	2.17	2.00	2.90
<b>Technical Skill/physical Effort</b>			
Technical skill required	2.29	1.86	3.10
Physical effort required	2.11	1.57	2.60
<b>Psychological Stress</b>			
The risk of significant complications, morbidity and/or mortality	3.06	1.57	2.90
Outcome depends on skill and judgment of physician	2.43	2.07	3.20
Estimated risk of malpractice suit with poor outcome	3.69	1.85	3.40
<b>Time Segments</b>			
PRE-service intensity/complexity	n/a	n/a	2.43
INTRA-service intensity complexity	2.12	2.08	2.50
POST-service intensity complexity	n/a	n/a	2.43

**ADDITIONAL RATIONALE:**

The time and complexity/intensity data presented above indicate that 90471 (CC1) is more work than 94010 and less work than 99212, the reference procedures. Although the survey respondents reported 10 minutes total time for 99212, HCFA "total" time estimates for this code are 14-15 minutes. Taking into account this difference in total time and the difference in intensity/complexity averages for the survey code and the reference procedures, the survey median RVW of 0.20 is recommended for 90471.

**FREQUENCY INFORMATION****How was this service previously reported?**

90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); single or combination vaccine/toxoid

**How often do physicians in your specialty perform this service? (✓ one)**

✓ Commonly      Sometimes      Rarely

**Estimate the number of times this service might be provided nationally in a one-year period?**

This is difficult to estimate because of the wide variety of application (eg, well-child immunizations, travelers to foreign countries, health care workers, annual flu vaccine, etc.)

**Is this service performed by many physicians across the United States? (✓ one)**

✓ Yes      No

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION**  
**Direct Practice Expense Inputs**

(April 1999)

**CPT Code:** 90471 (CC1)

**Global Period:** XXX

**CPT Descriptor:** Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); one vaccine (single or combination vaccine/toxoid)

**Reference Code 1:** 90782

**Reference Code 2:** 90788

**Specialty(s):** American Academy of Pediatrics

**CLINICAL LABOR (IN MINUTES)**

Clinical Staff	Staff Code	Pre-IN Office	TOTAL IN Office	Post-IN Office	Pre OUT Office	Intra OUT Office	Post OUT Office
RN/LPN/MA	10130	--	12	--	n/a	n/a	n/a

**MEDICAL SUPPLIES**

HCFA Supply Code	Supply Description	Unit	Quantity used IN-OFFICE for procedure AND pre- & post-op visits	QUANTITY used OUT-OF-OFFICE for pre- & post-op visits ONLY
NEW	APAP elixir 160mg/5ml (50% of the time)	ml	5	n/a
31502	band aid, 3/4" x 3"	item	1	n/a
11115	patient education sheet	item	1	n/a
31101	swab, alcohol	item	2	n/a
91408	syringe, 1ml	item	1	n/a
NEW	record sheet (AFP)	item	1	n/a
NEW	school record form	item	1	n/a

**PROCEDURE SPECIFIC MEDICAL EQUIPMENT**

HCFA Equip Code	Procedure-specific Description	Quantity used IN-OFFICE for procedure AND pre- & post-op visits	QUANTITY used OUT-OF-OFFICE for pre- & post-op visits ONLY
E13605	refrigerator	1	n/a

**OVERHEAD MEDICAL EQUIPMENT:**

HCFA Equip Code	Overhead Equipment Description	Office Quantity
E91002	crash cart, no defibrillator	1
E11001	exam table	2

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF WORK RECOMMENDATION

(April 1999)

**Recommended RVW: 0.18**

**CPT Code/ Tracking: 90472 (CC2)**

**Global Period: ZZZ**

**CPT Descriptor:** Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); each additional vaccine (single or combination vaccines/toxoids)

**Vignette Used in Survey:**

An 18-month old girl is seen for a well-child visit. In accordance with national recommendations for childhood immunizations, the pediatrician determines that the child should receive diphtheria, tetanus, and pertussis (DTaP) and varicella vaccinations. The parent is asked whether the child has had any reactions to previous DTaP immunizations. Since the varicella vaccine is relatively new and the child has not previously received a varicella immunization, the pediatrician discusses in depth the benefits and risks of providing the varicella vaccination with the parent. The parent is given DTaP and varicella vaccine information sheets. The child is given the DTaP immunization as an injection. During the same visit, the child is given the varicella vaccination as an injection. A dose of acetaminophen is given to the child at the office to reduce the incidence and severity of fever and irritability from the DTaP immunization. The immunization tracking numbers for each vaccine are entered into a computerized statewide registry.

**CLINICAL DESCRIPTION OF SERVICE (This work description was NOT provided on the survey.):**

**Description of Intra-service Work:**

The physician discusses with the patient/parent/guardian the benefits and risks for a necessary/required second (or third, or fourth, etc) vaccine/toxoid administration. If the vaccine/toxoid has been administered previously, the patient/parent/guardian is questioned about previous reactions. Available pertinent informational material is provided to the patient/parent/guardian. The vaccine/toxoid is administered, along with a dose of acetaminophen, if appropriate. The immunization tracking number is entered into a computerized statewide registry.

**SURVEY DATA:**

**Presenter(s):** Steven Krug, MD

**Specialty(s):** American Academy of Pediatrics

**Sample Size: 180    Response Rate (No. and %): 32 (17.8%)**

**Type of Sample (✓ one):**    random    ✓ panel    ~~convenience~~

<b>Survey RVW</b>	<b>Low: 0.12</b>	<b>25th%: 0.17</b>	<b>Med: 0.18</b>	<b>75th%: 0.33</b>	<b>High: 0.88</b>
-------------------	------------------	--------------------	------------------	--------------------	-------------------

<b>Survey Total Time</b>	<b>Low: 3</b>	<b>25th%: 5</b>	<b>Med: 7</b>	<b>75th%: 10</b>	<b>High: 25</b>
--------------------------	---------------	-----------------	---------------	------------------	-----------------

**KEY REFERENCE SERVICE(S):**

<u>1999 RVW</u>	<u>Global</u>	<u>CPT</u>	<u>Descriptor</u>
0.17	XXX	94010	Spirometry, including graphic record, total and times vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

	<i>Mean</i> Intensity/Complexity Measures		
	90472	94010	N/A*
<b>Time Estimates (Median)</b>	90472	94010	N/A*
PRE-service time	n/a	n/a	--
INTRA-service time (TOTAL time for XXX global)	7	6	--
POST-service time	n/a	n/a	--
<b>Mental Effort and Judgment</b>			
The number of possible diagnosis and/or the number of management options that must be considered	2.35	2.33	--
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained reviewed and analyzed	2.68	2.58	--
Urgency of medical decision making	2.1	2.00	--
<b>Technical Skill/physical Effort</b>			
Technical skill required	2.23	1.83	--
Physical effort required	2.13	1.50	--
<b>Psychological Stress</b>			
The risk of significant complications, morbidity and/or mortality	2.97	1.50	--
Outcome depends on skill and judgment of physician	2.42	1.92	--
Estimated risk of malpractice suit with poor outcome	3.65	2.27	--
<b>Time Segments</b>			
PRE-service intensity/complexity	2.68	1.73	--
INTRA-service intensity complexity	2.28	2.08	--
POST-service intensity complexity	2.25	2.09	--

\*No other code was reported with a high enough frequency to report a meaningful mean measure of intensity/complexity.

**ADDITIONAL RATIONALE:**

Although it is an add-on code, new code 90472 (CC2) is only minimally less work than 90471 (CC1). With the provision of each additional vaccine come increased time requirements on the part of the physician for the legally required counseling of parents/guardians regarding the relative risks and benefits of vaccines and assessing the medical history to determine the safety of administering vaccines. Additionally, it should be noted that multiple vaccines at one visit may be administered by various means (eg, oral, intranasal, and/or injection). The median RVW of 0.18 for 90472 is recommended and reflects this work.

**FREQUENCY INFORMATION**

**How was this service previously reported?**

90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); two or more single or combination vaccine/toxoids

**How often do physicians in your specialty perform this service? (✓ one)**

✓ Commonly      Sometimes      Rarely

**Estimate the number of times this service might be provided nationally in a one-year period?**

This is difficult to estimate because of the wide variety of application (eg, well-child immunizations, travelers to foreign countries, health care workers, annual flu vaccine, etc.)

**Is this service performed by many physicians across the United States? (✓ one)**

✓ Yes      No

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION  
Direct Practice Expense Inputs**

(April 1999)

**CPT Code:** 90472 (CC2) **Global Period:** XXX

**CPT Descriptor:** Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections and/or intranasal or oral administration); each additional vaccine (single or combination vaccines/toxoids)

**Reference Code 1:** 90782

**Reference Code 2:** 90788

**Specialty(s):** American Academy of Pediatrics

**CLINICAL LABOR (IN MINUTES)**

Clinical Staff	Staff Code	Pre-IN Office	TOTAL IN Office	Post-IN Office	Pre OUT Office	Intra OUT Office	Post OUT Office
RN/LPN/MA	10130	-	9	-	n/a	n/a	n/a

**MEDICAL SUPPLIES**

HCFA Supply Code	Supply Description	Unit	Quantity used IN-OFFICE for procedure AND pre- & post-op visits	QUANTITY used OUT-OF-OFFICE for pre- & post-op visits ONLY
NEW	APAP elixir 160mg/5ml (50% of the time)	ml	5	n/a
31502	band aid, 3/4' x 3"	item	1	n/a
11115	patient education sheet	item	1	n/a
31101	swab, alcohol	item	2	n/a
91408	syringe, 1ml	item	1	n/a
NEW	record sheet (AFP)	item	1	n/a
NEW	school record form	item	1	n/a

**PROCEDURE SPECIFIC MEDICAL EQUIPMENT**

HCFA Equip Code	Procedure-specific Description	Quantity used IN-OFFICE for procedure AND pre- & post-op visits	QUANTITY used OUT-OF-OFFICE for pre- & post-op visits ONLY
E13605	refrigerator	1	n/a

**OVERHEAD MEDICAL EQUIPMENT:**

HCFA Equip Code	Overhead Equipment Description	Office Quantity
E91002	crash cart, no defibrillator	1
E11001	exam table	2

## **Revisions to RUC Database Vignettes**

### **90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); one vaccine (single or combination vaccine/toxoid)**

A 17-year-old patient is seen for a preventive medicine visit. In accordance with national recommendations for immunizations, the physician determines that the patient should receive a hepatitis B vaccination. The patient/parent/guardian is asked about any previous immunization reactions and is given the CDC vaccine information sheet (VIS) on hepatitis B. The physician reviews the benefits and risks of providing the hepatitis B vaccination with the patient/parent/guardian. After consent, the patient is given the hepatitis B immunization as an injection. The immunization tracking number is entered into a computerized statewide registry.

### **90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)**

A 17-year-old patient is seen for a preventive medicine visit. In accordance with national recommendations for immunizations, the physician determines that the patient should receive hepatitis B and meningococcal vaccinations. The patient/parent/guardian is asked about any previous immunizations reactions and is given the CDC vaccine information sheets (VIS) on both hepatitis and meningococcal vaccines. The patient is first given the hepatitis B immunization as an injection. During the same visit, the patient receives a meningococcal vaccination as an additional injection. The immunization tracking numbers for each vaccine are entered into a computerized statewide registry.

## Vignettes for 90465 - 90468

### Vignette:

An 18-month old girl is seen for a well-child visit. In accordance with national recommendation for childhood immunizations, the pediatrician determines that the child should receive a diphtheria, tetanus, and pertussis (DTaP) vaccination.

### Description of Work:

The physician first reviews the previous experience with the vaccine and determines if there are any contraindications prior to proceeding. A vaccine information sheet (VIS) is given to the parent/guardian for the DTaP vaccine, and in keeping with state and federal laws, the information including risks and benefits of DTaP vaccine are discussed with the parent/guardian in detail, and a discussion occurs with the patient about the vaccine and the diseases it protects against. Appropriate documentation is entered into the patient record {an electronic copy of a sample Vaccine Administration Record appears at the end of this proposal}. The documentation for the vaccine includes: which VIS was given; the date of the publication of the VIS; the date the VIS was given; the name, address, & title of the person who administered the vaccine; the date of administration; the vaccine manufacturer; and the vaccine lot number. Additionally, the appropriate types and doses of medications to alleviate fever and pain at the injection site are discussed. Since the physician participates in the Vaccines for Children (VFC) program, the nurse obtains the vaccine from the appropriate inventory, making sure to document which supply of vaccines was used for this particular patient. Although federal law does not mandate separate vaccine inventories, the Centers for Disease Control and Prevention (CDC) strongly recommend them for reasons of accountability. Informed consent is obtained by the physician who then orders the nurse to prepare the vaccine. The nurse prepares the DTaP vaccine using a safe sharp syringe and administers the vaccine. The patient is observed in the office for an immediate allergic reaction and then is discharged home by the nurse. The immunization tracking number is entered into a computerized statewide registry.

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April and October 2004

**Tissue Debridement of Genitalia for Gangrene**

The CPT Editorial Panel in February 2004 created four new codes for performing a debridement for Fournier's Gangrene. Existing excision and debridement codes were not specific to the urogenital system where debridements are extensive and involve removal/transplantation of the genital organs such as the penis or testes. In addition, these procedures are usually performed emergently in high risk patients with over 50% mortality rates. Two of the four codes were brought forth by specialties in April 2004 and re-reviewed in September 2004 and the other two codes were reviewed by the RUC in September 2004. CPT codes 11004, 11005 and 11006 have each been assigned a global period of 000 because the post-operative link is so variable. The RUC reviewed the typical patient scenario for all four codes and understood that the new codes would never be performed in the physician's office due to fact that these patients were at high risk and emergent.

**11004**

In April 2004, the RUC reviewed and compared the work of 000 day global codes 11012 *Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, muscle, and bone* (RUC Surveyed, MPC listed, Work RVU=6.87) and 43242 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum and/or jejunum as appropriate)* (RUC Surveyed, Work RVU = 7.30). Both codes have an intra-service work time of 90 minutes which is identical to new code 11004. The RUC believed that code 11004 is significantly more intense than code 11012 and at a higher risk. It was explained that for these new codes the physician is actually filleting the skin. In addition, the RUC believed the intensity of code 43242 was similar for this emergency room procedure. The RUC then used the intra-service work intensity of 43242 to establish a work RVU for code 11004. The RUC believed that the pre-service time associated with these codes should reflect the existence of an extensive E/M code prior to the service, and recommended decreasing the pre-service evaluation time by 15 minutes. The pre and immediate post service time for 11004 and 11006 was justified to the RUC as being longer and more involved than the time needed for code 43242. The RUC used the building block approach using the intensity of 43242, with the understanding that the work of 11004 is more involved. The RUC used an intra-service work per unit of time (IWPUT) of .077 to establish a work RVU for 11004 of 8.80.

However, at the September 2004 meeting, the RUC identified that a separate E/M visit does occur with 11004 and 11006. The RUC addressed that the post-service time should be revised to demonstrate accuracy. Therefore, a 99233 (RVU=1.51) post-operative visit should be added to 11004 and 11006 without affecting the IWPUT. **The RUC recommends adding 1.51 RVUs to 11004. The RUC recommends a work RVU of 10.31 (8.80+1.51) for 11004.**

### **11005**

The RUC reviewed the survey data of 11005 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection of abdominal wall, with or without fascial closure*. The survey responses indicated a significantly higher intensity of technical skill and physical effort; psychological stress and pre-service, intra-service and post-service time segments for 11005 as compared to the reference service code of 15000 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children* (RVU=3.99). The RUC also compared 11005 to reference code 34833 *Open iliac artery exposure with creation of conduit for delivery of infrarenal aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral* (RVU=11.98). The sum of 34833 plus the 99233 post-op visit equals 13.49 (11.98+1.51). Therefore, since the operative intensity of 11005 has a greater intensity than 34833, the survey median RVU of 13.75 appeared appropriate. The facilitation committee reviewed the AUA survey data from 2003 for 11005 and compared it to the ACS survey data for the September, 2004 RUC meeting. The pre-, intra- and post- service times of the two codes were almost identical, however it was noted that 11005 is often associated with removal of infected synthetic mesh necessitating a formal closure of the peritoneal cavity. Although there is an add-on code for removal of the infected mesh, the added work of the abdominal/peritoneal closure after removing the mesh was felt by the committee to justify a slightly higher RVU of 13.75 (an additional 1.14 RVUs), thereby resulting in a slightly higher intensity for 11005. **The RUC recommends the survey median work RVU of 13.75 for code 11005.**

### **11006**

In April 2004, the RUC used the same building block approach used in 11004 to develop a work RVU for code 11006. The RUC used the IWPUT of code 43242 (0.077) to establish a work RVU of 11.10 for 11006. In addition, the RUC also believed the intra-time associated with these procedures was not sufficiently reflected in the specialty's survey results. The RUC understood that the intra-service physician time for 11006 had to be more than the intra-service time for code 11004 and accepted the specialty's recommendation for the 75<sup>th</sup> percentile surveyed results of 120 minutes. The RUC also reviewed 000 day global code 93620 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording* (RUC Surveyed, MPC listed, Work RVU =11.57) for its complexity and work in relation to this new service. Code 93620 has a RUC surveyed pre-service time of 60 minutes, intra-service time of 120 minutes, and 60 minutes of post service time.

However, at the September 2004 meeting, the RUC identified that a separate E/M visit does occur with 11004 and 11006. The RUC addressed that the post-service time should be revised to demonstrate accuracy. Therefore, a 99233 (RVU=1.51) post-operative visit should be added to 11004 and 11006 without affecting the IWP/UT. **The RUC recommends adding 1.51 RVUs to 11006. The RUC recommends a work RVU of 12.61 (11.10+1.51) for 11006.**

**11008**

The RUC reviewed the survey data for 11008 *Removal of prosthetic material or mesh, abdominal wall for necrotizing soft tissue infection (List separately in addition to code for primary procedure)*. The survey responses indicated a higher intensity of mental effort and judgment; technical skill and physical effort; psychological stress and median intra-service time for 11008 as compared to the reference service code of 49568 *Implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to code for the incisional or ventral hernia repair)* (RVU = 4.88). **The RUC recommends the median Work RVU of 5.00 for code 11008.**

**The RUC recommends the following physician time and relative work values:**

<b>CPT Code</b>	<b>Pre-Service Evaluation Time</b>	<b>Pre-Service Positioning Time</b>	<b>Pre-Service Scrub, Dress, Wait Time</b>	<b>Intra-Service Time</b>	<b>Immediate Post Service Time</b>	<b>Post-Operative Visit</b>	<b>Recommended RVU</b>
11004	30	15	20	90	30	1 - 99233	10.31
11005	30	15	15	120	30	1 - 99233	13.75
11006	30	15	20	120	30	1 - 99233	12.61
11008	0	0	0	60	0		5.00

**Practice Expense for 11004, 11005, 11006 and 11008**

The RUC agreed that these procedures are performed on an emergent basis in the facility setting only, and would not have any direct practice expense inputs.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
11000		Debridement of extensive eczematous or infected skin; up to 10% of body surface  <u>(For abdominal wall or genitalia debridement for necrotizing soft tissue infection, see code 1104X1-1104X3)</u>	000	0.60  (No Change)
● 11004	T1	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection of external genitalia and perineum	000	10.31  (Updated from May 2004 submission)
● 11005	T2	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection of abdominal wall, with or without fascial closure	000	13.75
● 11006	T3	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection of external genitalia, perineum and abdominal wall, with or without fascial closure	000	12.61  (Updated from May 2004 submission)
+ ● 11008	T4	<u>Removal of prosthetic material or mesh, abdominal wall for necrotizing soft tissue infection (List separately in addition to code for primary procedure)</u>  <u>(Use 1104X4 in conjunction with 1104X1-1104X3)</u>  <u>(Report skin grafts or flaps separately when performed for closure at the same session as 1104X1-1104X4)</u>  <del>(When insertion of mesh is used for closure, use 49568)</del>	ZZZ	5.00

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:11004 Tracking Number:      Global Period: 000      **Recommended Work Relative Value**  
Specialty Society RVU: 10.75      RUC RVU: 10.31

CPT Descriptor: Debridement of skin subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection of external genitalia and perineum

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 56-year-old diabetic male presents to the emergency room with a two-day history of increasing fever. On physical examination, he appears dehydrated with a fever of 102.6. There are patchy areas of full thickness skin necrosis with surrounding erythema involving his scrotum, perineum and base of the penis. Laboratory examination reveals a white blood count of 18.6 and a blood sugar of 42. he is given fluid resuscitation and IV antibiotics. Since he has necrotizing soft tissue infection (Fournier's Gangrene), he is taken to the operating room for immediate debridement.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Change into scrub attire
- Review surgical procedure, post-op recovery period with patient and family
- Answer questions from the patient and family
- Make sure that informed consent is completed and in the record
- Speak to anesthesiologist about expected length of procedure and about special concerns about the patient (sepsis, shock)
- Position patient on the operating table

**Description of Intra-Service Work:**

- The patient is taken to the operating room and placed in the supine position with the legs apart
- The field is sterilized, prepped and draped
- Under anesthesia the extent of the necrotic tissue is evaluated
- Necrotic skin, subcutaneous tissue, fat and muscle is resected/debrided back to healthy tissue
- The penis is debrided as necessary
- The Scrotum is debrided as necessary
- Through and through Penrose drains are placed
- The wounds are packed open with saline soaked gauze
- The Foley catheter is left in place

**Description of Post-Service Work:**

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed

- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and discuss any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, in ICU or hospital bed, check wound and patient progress
- Review patient hospital medical record notes
- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

### SURVEY DATA

<b>RUC Meeting Date (mm/yyyy)</b>		04/2004			
<b>Presenter(s):</b>	Jeffery A. Dann, M.D.				
<b>Specialty(s):</b>	American Urological Association				
<b>CPT Code:</b>	11004				
<b>Sample Size:</b>	985	<b>Resp n:</b>	43	<b>Response:</b> 4.36 %	
<b>Sample Type:</b>	Random				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	4.90	10.75	13.50	20.00	28.00
<b>Pre-Service Evaluation Time:</b>			30.0		
<b>Pre-Service Positioning Time:</b>			15.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			20.0		
<b>Intra-Service Time:</b>	45.00	60.00	90.00	120.00	300.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
<b>Immed. Post-time:</b>	<u>30:00</u>				
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<u>41.0</u>	99231x 0.0	99232x 0.0	99233x 1.0	
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00		
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

### KEY REFERENCE SERVICE:

Key CPT Code  
50020

Global  
090

Work RVU  
14.64

CPT Descriptor Drainage of perirenal or renal abscess;open

Other Reference CPT Code  
11012

Global  
000

Work RVU  
6.87

CPT Descriptor Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, muscle, and bone

### RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9      % of respondents: 20.9 %

#### TIME ESTIMATES (Median)

	New/Revised CPT Code: 11004	Key Reference CPT Code: 50020
Median Pre-Service Time	65.00	70.00
Median Intra-Service Time	90.00	90.00
Median Immediate Post-service Time	30.00	0.00
Median Critical Care Time	0.0	120.00
Median Other Hospital Visit Time	41.0	133.00
Median Discharge Day Management Time	0.0	36.00
Median Office Visit Time	0.0	92.00
Median Total Time	226.00	541.00

#### INTENSITY/COMPLEXITY MEASURES (Mean)

##### Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	4.50	3.50

##### Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.00
Physical effort required	3.50	3.00
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	4.50	3.00
Outcome depends on the skill and judgment of physician	4.00	3.00
Estimated risk of malpractice suit with poor outcome	4.50	3.00

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.50	3.50
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity	3.50	3.50

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

IWPUT for the new/revised CPT code - 0.087

Our RUC recommendations are based on survey responses from urologists located across the country, including urologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of urologists comprised of a representative sample of the above described group convenes to examine the data associated with each code and determine the final RUC recommendation.

The committee felt that the median times were appropriate for this procedure, however, the 25<sup>th</sup> percentile RVU of 10.75 was felt to be more reflective of the work.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Currently CPT codes 11040-11044 are utilized to report this service. When an orchiectomy or testicular transplantation is performed at the same sitting, CPT 54520 or 54680 respectively would be also requested with the appropriate modifier.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AUA                                      How often? Sometimes

Specialty    How often?

Specialty    How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2000  
 If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty                      Frequency 0                      Percentage                      %

Specialty                      Frequency 0                      Percentage                      %

Specialty                      Frequency 0                      Percentage                      %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
 1,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty                      Frequency 0                      Percentage                      %

Specialty                      Frequency 0                      Percentage                      %

Specialty                      Frequency 0                      Percentage                      %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 11012 is a better crosswalk, and should have been the reference code in hindsight.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:11005 Tracking Number: T2 Global Period: 000

**Recommended Work Relative Value**  
Specialty Society RVU: 13.75  
RUC RVU: 13.75

CPT Descriptor: Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection of abdominal wall, with or without fascial closure

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 43-year-old man is 10 days s/p repair of colon wound, secondary to a shotgun injury to the abdomen. The man has a fever of 103.2°F and appears dehydrated and toxic. His partially opened abdominal midline wound has areas of full thickness skin necrosis with surrounding erythema and crepitus involving large areas of the abdominal wall skin, subcutaneous tissue, fascia, and muscle. His WBC is 25,000. He was started on fluid resuscitation and I.V. antibiotics. Since he has fulminating necrotizing fasciitis, he requires immediate debridement. At operation, complete debridement of all involved skin, subcutaneous tissue, fascia, and muscle is carried out. The wounds are packed, dressed, and the fascia is partially reapproximated.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Write pre-operative orders for peri-operative medications; Review pre-operative work-up, with particular attention to microbiology reports; Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family; Answer patient and family questions and obtain informed consent; Begin and ensure adequate fluid resuscitation and cardiovascular stability. Review planned incisions and procedure; Change into scrub clothes; Review with anesthesiology the induction / intraoperative plan for maintaining circulatory flow and possible transfusions. Review length and type of anesthesia with anesthesiologist; Review planned procedure and positioning and draping of patient; Verify that all necessary surgical instruments and supplies are readily available in the operative suite; Monitor patient positioning and draping, and assist with positioning as needed; Scrub and gown.

Description of Intra-Service Work: The skin is opened in its entirety, and the fascia opened along the necrotic portion. The necrotic skin, subcutaneous tissue, fascia, and underlying muscle of the rectus abdominus and external oblique are debrided by sharp dissection. Multiple abscesses are entered and drained. The debridement is then carried cephalad, caudal, and laterally until healthy muscle and subcutaneous tissue is reached and all of the necrotic / abscessed tissue is removed and all areas of hemorrhage is controlled. All wound areas are irrigated with copious amounts of saline and then antibiotic solution. Multiple drains are placed in all wound sites and the wound beds are packed with saline soaked gauze. The abdominal fascia is partially reapproximated with sutures to help prevent evisceration of bowel and to protect exposed viscera in areas without peritoneum.

**Description of Post-Service Work:**

Post-op Same day work through discharge from recovery

Apply dressings; Write orders for post-op labs, films, medications, diet, and patient activity; Review recovery room care and medications with staff; Discuss procedure outcome with family; Discuss procedure outcome with patient after emergence from anesthesia; Dictate post-op report; Discuss procedure outcome with referring physician; Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company

Post-op Same day work after discharge from recovery

Examine patient, check wounds and patient progress; Review nursing/other staff patient chart notes; Answer patient family questions; Answer nursing/other staff questions; Write orders for following day's labs, films, medications, diet, and patient activity; Chart patient progress notes

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004				
<b>Presenter(s):</b>	Charles Mabry, MD, FACS					
<b>Specialty(s):</b>	American College of Surgeons					
<b>CPT Code:</b>	11005					
<b>Sample Size:</b>	70	<b>Resp n:</b>	37	<b>Response:</b> 52.85 %		
<b>Sample Type:</b> Random						
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>		6.30	9.00	13.75	16.00	18.00
<b>Pre-Service Evaluation Time:</b>				30.0		
<b>Pre-Service Positioning Time:</b>				15.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				15.0		
<b>Intra-Service Time:</b>		60.00	90.00	120.00	150.00	300.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>30.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>41.0</u>	99231x 0.0	99232x 0.0	99233x 1.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
15000	000	3.99

CPT Descriptor Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
-----------------------	---------------	-----------------

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
-----------------------	---------------	-----------------

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
34833	000	11.98

CPT Descriptor Open iliac artery exposure with creation of conduit for delivery of infrarenal aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15      % of respondents: 40.5 %

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 11005</u>	<u>Key Reference CPT Code: 15000</u>
Median Pre-Service Time	60.00	0.00
Median Intra-Service Time	120.00	30.00
Median Immediate Post-service Time	30.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	41.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	251.00	30.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.27	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.73	4.07
Urgency of medical decision making	4.93	3.00

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.33	3.67
Physical effort required	3.87	3.20

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.93	3.53
Outcome depends on the skill and judgment of physician	4.73	4.27
Estimated risk of malpractice suit with poor outcome	3.93	4.27

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.47	3.36
Intra-Service intensity/complexity	4.60	3.60
Post-Service intensity/complexity	4.67	3.00

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The survey median RVW of 13.75 is recommended for 11005. The total work for this new code is significantly greater than for reference code 15000 (three to four times more work by magnitude estimation). Operative exposure for the second reference code 34833 is much smaller and performed as an outpatient service, compared with the significantly greater exposure for 11005 performed on a hospitalized patient in ICU. The sum of 34833 plus 99233 is 13.49 (11.98+1.51). If you consider that the operative intensity of 11005 is greater than 34833, then the survey median RVW of 13.75 is an appropriate relative value.

The IWPUT of 110005 with an RVW of 13.75 is 0.087.

IWPUT BBM Analysis		RVW	
Svy RVW: 13.75			
Svy Data	RUC Std.	RVW	
Pre-service: Time	Intensity	(=time x intensity)	
Pre-service eval & positioning	45	0.0224	1.01
Pre-service scrub, dress, wait	15	0.0081	0.12
Pre-service total	1.13		
Post-service: Time	Intensity	(=time x intensity)	
Immediate post	30	0.0224	0.67
Subsequent visits: Visit n	E/M RVW	(=n x RVW)	
99233 1	1.51	1.51	
Post-service total		2.18	
Time	IWPUTINTRA-RVW		
Intra-service: 120	0.087	10.44	

---

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

---

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11043-22 Debridement; skin, subcutaneous tissue, and muscle

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery

How often? Sometimes

Specialty

How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 34833

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

**Recommended Work Relative Value**

CPT Code:11006 Tracking Number:      Global Period: 000      Specialty Society RVU: **13.99**      RUC RVU: **12.61**

CPT Descriptor: Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia, perineum and abdominal wall, with or without fascial closure

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 48 - year old leukemic male presents to the emergency room with a 24-hour history of fever and dehydration. On physical examination, he appears dehydrated with a fever of 103.2. There are areas of full thickness skin necrosis with surrounding erythema and crepitus involving large areas of the scrotum, perineum, base of penis, upper thighs, and lower abdominal wall. Laboratory examination demonstrates an elevated white blood count and a creatinine of 2.8. He is given fluid resuscitation and I.V. antibiotics. Since he has fulminating necrotizing fasciitis (Fournier's Gangrene), he is taken to the operating room for immediate debridement of all these involved tissues.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

**Description of Pre-Service Work:**

- Change into scrub cloths
- Review surgical procedure, post-op recovery with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (sepsis, shock)
- Position patient on operating table

**Description of Intra-Service Work:**

- The patient is taken to the operating room and placed in the supine position with the legs apart
- The field is sterilized, prepped and draped Under anesthesia the extent of the necrotic tissue is evaluated
- Necrotic skin, subcutaneous tissue, fat and muscle is resected/debrided back to healthy tissue
- The penis is debrided as necessary
- The Scrotum is debrided as necessary
- Lower abdominal tissue is resected to healthy tissue and Jackson - Pratt drains are placed
- Through and through Penrose drains are placed
- The wounds are packed open with saline soaked gauze
- The Foley catheter is left in place

**Description of Post-Service Work:**

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care
- Discuss procedure with patient as necessary in recovery area when awake
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)

- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, in ICU or hospital bed, check wound and patient progress
- Review patient hospital medical record notes Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		04/2004				
<b>Presenter(s):</b>	Jeffery A. Dann, M.D.					
<b>Specialty(s):</b>	American Urological Association					
<b>CPT Code:</b>	11006					
<b>Sample Size:</b>	985	<b>Resp n:</b>	42	<b>Response:</b> 4.26 %		
<b>Sample Type:</b> Random						
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RWV:</b>		4.94	10.06	13.99	16.00	300.00
<b>Pre-Service Evaluation Time:</b>				30.0		
<b>Pre-Service Positioning Time:</b>				15.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				20.0		
<b>Intra-Service Time:</b>		15.00	60.00	120.00	120.00	180.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<b>30.00</b>					
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<b>41.0</b>	99231x 0.0	99232x 0.0	99233x 1.0		
<b>Discharge Day Mgmt:</b>	<b>0.0</b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b>0.0</b>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
50020	090	14.64

CPT Descriptor Drainage of perirenal or renal abscess;open

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
11012	000	6.87

CPT Descriptor Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, muscle, and bone

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9      % of respondents: 21.4 %

**TIME ESTIMATES (Median)**

	New/Revised CPT Code: 11006	Key Reference CPT Code: 50020
Median Pre-Service Time	65.00	70.00
Median Intra-Service Time	120.00	90.00
Median Immediate Post-service Time	30.00	0.00
Median Critical Care Time	0.0	120.00
Median Other Hospital Visit Time	41.0	133.00
Median Discharge Day Management Time	0.0	36.00
Median Office Visit Time	0.0	92.00
Median Total Time	256.00	541.00

**INTENSITY/COMPLEXITY MEASURES (Mean)**

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	5.00	3.00

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.00	3.00
Physical effort required	3.00	4.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	5.00	3.00
Outcome depends on the skill and judgment of physician	4.00	3.00
Estimated risk of malpractice suit with poor outcome	4.00	3.00

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	4.00	3.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.00	3.00
------------------------------------	------	------

Post-Service intensity/complexity	3.00	3.00
-----------------------------------	------	------

## ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

IWP/UT for new/revised CPT code 11006 - 0.086

Our RUC recommendations are based on survey responses from urologists located across the country, including urologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of urologists comprised of a representative sample of the above described group convenes to examine the data associated with each code and determine the final RUC recommendation.

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Currently CPT codes 11040-11044 are utilized to report this service. When an orchiectomy or testicular transplantation is performed at the same sitting, CPT 54520 or 54680 respectively would be also requested with the appropriate modifier.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty AUA                      How often? Sometimes

Specialty                              How often?

Specialty                              How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty AUA              Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 500

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty AUA              Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 11012 is a better crosswalk, and should have been the reference code in hindsight.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

---

CPT Code:11008 Tracking Number: T4 Global Period: ZZZ

**Recommended Work Relative Value**

Specialty Society RVU: **5.00**

RUC RVU: **5.00**

CPT Descriptor: Removal of prosthetic material or mesh, abdominal wall for necrotizing soft tissue infection (List separately in addition to code for primary procedure)

---

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 50-year-old man has had recurrent draining sinuses along and associated with a 12 month-old abdominal midline ventral hernia repair. He has had recurrent subcutaneous abscesses drained, with previously isolated gram-negative organisms. The repeated use of broad-spectrum antibiotics and local wound care has failed to resolve the recurrent infections. He now presents with infected polypropylene mesh in the hernia repair. During the primary procedure, the entire 6 x 4 inch section of mesh is removed by sharp dissection. (Note: Wound debridement, exploratory laparotomy, hernia repair, intestinal repair, or repair of intestinal fistula are reported separately. When completing this survey, consider only the "add-on" work associated with 11008.)

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: n/a

Description of Intra-Service Work: The mesh is completely exposed by sharp dissection and carefully dissected free, circumferentially, from the subcutaneous tissue, fascia, and muscle. As it is removed, it is carefully and sharply dissected free from any underlying omentum and intestines. The mesh is completely removed. Any associated laparotomy, wound debridement, intestinal or fistula repair, or wound repair is reported separately.

Description of Post-Service Work: n/a

---

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004				
<b>Presenter(s):</b>	Charles Mabry, MD, FACS					
<b>Specialty(s):</b>	American College of Surgeons					
<b>CPT Code:</b>	11008					
<b>Sample Size:</b>	70	<b>Resp n:</b>	32	<b>Response:</b> 45.71 %		
<b>Sample Type:</b> Random						
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>		3.00	4.80	5.00	6.00	9.00
<b>Pre-Service Evaluation Time:</b>				0.0		
<b>Pre-Service Positioning Time:</b>				0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				0.0		
<b>Intra-Service Time:</b>		30.00	44.00	60.00	90.00	180.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>0.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
49568	ZZZ	4.88

CPT Descriptor Implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to code for the incisional or ventral hernia repair)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
-----------------------	---------------	-----------------

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
-----------------------	---------------	-----------------

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
44121	ZZZ	4.44

CPT Descriptor Enterectomy, resection of small intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 17      % of respondents: 53.1 %**

<b><u>TIME ESTIMATES (Median)</u></b>	<b>New/Revised CPT Code: 11008</b>	<b>Key Reference CPT Code: 49568</b>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	60.00	52.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
<b>Median Total Time</b>	<b>60.00</b>	<b>52.00</b>
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.47	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.71	2.44
Urgency of medical decision making	3.88	3.44

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.35	3.44
Physical effort required	4.29	3.94

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.38	3.38
Outcome depends on the skill and judgment of physician	3.88	3.50
Estimated risk of malpractice suit with poor outcome	3.53	3.44

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	4.41	3.44
Post-Service intensity/complexity	0.00	0.00

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The survey median RVW of 5.00 is recommended for 11008. This value is slightly higher than the reference code 49568 [Implantation of mesh or other prosthesis for incisional or ventral hernia repair], reflecting the increased intensity and complexity to remove the mesh within a site of infection.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.  
 Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.  
 Multiple codes allow flexibility to describe exactly what components the procedure included.  
 Multiple codes are used to maintain consistency with similar codes.  
 Historical precedents.  
 Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. At least one of the primary debridement codes 1104X1-1104X3 will always be reported with this add-on code.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49999 Unlisted procedure, abdomen, peritoneum and omentum



AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

October 2004

**Endometrial Cryoablation Therapy**

CPT created a new code 58356 *Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed* to describe endometrial cryoablation with ultrasonic guidance since there are no existing codes that accurately describe the clinical distinctions of uterine cryoablation. Given the survey results that were based on a comparison with code 58563, *Hysteroscopy, surgical; with endometrial ablation (egg, endometrial resection, electrosurgical ablation, thermoablation)* (work RVU = 6.16), the RUC and the presenters concluded that the intra-service intensity of the two codes were equal, however the RUC also agreed that the physician time estimates from the survey were incorrect. The RUC made a number of adjustments to the time for code 58356 *Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed*. Pre-service time was reduced by 10 minutes and the RUC assigned a half discharge day rather than a full discharge day. The presenters explained that the survey respondents underestimated the intra-service time and while the survey median was 40 minutes, the presenters felt that the 75<sup>th</sup> percentile of 45 minutes more accurately reflected the intra-service time. The presenters also stated that this time would be a more accurate comparison with the reference service's intra-service time of 60 minutes. The committee agreed that an IWP/UT of .076 which is the intensity measure of the reference service should also be applied to code 58356 as well as 45 minutes of intra-service time. The committee discussed these changes in detail and agreed to the following adjustments and recommended value.

Pre evaluation time	30
Positioning time	10
Scrub time	10
Intra-service time	45 @iwput 0.076
Immediate post time	30
Discharge day	.5 of 99238
Office visits	1 X 99213

An analysis of this time and intensity results in an RVU of 6.36. The RUC agreed that the rank order between 58356 (recommended work RVU = 6.36) and the reference service 58563 (work RVU = 6.16) would be correct. The RUC also noted that this work RVU is

equivalent to code 46260 Hemorrhoidectomy, internal and external, complex or extensive (work RVU = 6.36), which is included on the RUC's MPC list.

**The RUC recommends a work RVU of 6.36 for code 58356.**

Practice Expense

The RUC reviewed the direct practice expense inputs and made changes to the clinical staff inputs in the service period as well as applied standard post op visit time for follow-up phone calls. A cryoablation machine was also added as equipment. The details of the practice expense inputs are attached to the recommendations.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
58340		<p><i>Catheterization and introduction of saline or contrast material for hysterosonography or hysterosalpingography</i></p> <p><i>(For radiological supervision and interpretation of hysterosonography, see 76831)</i></p> <p><i>(For radiological supervision and interpretation of hysterosalpingography, see 74740)</i></p> <p><del><i>(For endometrial cryoablation with ultrasonic guidance, use Category III code 0009T)</i></del></p>	000	0.88 (No Change)
58353		<p><i>Endometrial ablation, thermal, without hysteroscopic guidance</i></p> <p><i>(For hysteroscopic procedure, use 58563)</i></p>	010	3.55 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●58356	AJ1	Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed  <u>(Do not report 58356 in conjunction with 58100, 58120 58340, 76700, 76856)</u>	010	6.36
<del>0009T</del>		<del>Endometrial cryoablation with ultrasonic guidance</del>  <u>(0009T has been deleted. To report, use 5835X)</u>	XXX	N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:58356 Tracking Number: AJ1 Global Period: 010

**Recommended Work Relative Value**

Specialty Society RVU: 6.80

RUC RVU: 6.36

CPT Descriptor: Endometrial cryoablation with ultrasonic guidance including endometrial curettage when performed (Do not report 58356 in conjunction with 58100, 58120, 58340, 76700, 76856)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: The typical patient is a 42 year old premenopausal woman who presents with menorrhagia due to benign causes and for whom childbearing is complete. Appropriately selected patients include women with abnormal uterine bleeding where conservative therapy (hormonal therapy and/or D&C) has failed and hysterectomy is the next treatment option considered by her physician. Endometrial cryoablation therapy is contraindicated in patients with known or suspected endometrial carcinoma or premalignant changes in the endometrium, or any anatomic or pathologic condition in which weakness of the myometrium could exist. Active genital infection, active pelvic inflammatory disease, active UTI, or intrauterine device (IUD) currently in place is ruled out.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 46%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Patient is counseled and consent obtained. Patient is positioned, prepped, and draped. Cryoablation equipment is prepped, draped, and warmed up. Ultrasound machine to prepped, draped, and warmed up. Appropriate anesthetic is administered, including paracervical block.

Description of Intra-Service Work: Probe is connected to cryoablation console and sterile drape deployed. Machine is precooled. Foley catheter placed and bladder is filled. Tenaculum placed on anterior cervical lip and traction applied. Cervical canal is evaluated and dilated. Suction curettage is typically performed. Ultrasound is used to observe and direct cryoprobe probe. Probe is inserted to the fundus and directed towards one cornu. Sterile saline is injected and uterus evaluated for air and visualization. First freeze is initiated. Cryoprobe tip temperature cooled to minus 60 degrees Celsius. The cryozone is monitored on ultrasound to ensure cryozoned does not extend beyond the serosa. When this freeze is complete, a heat cycle is initiated in the cryoprobe. Once the tip reaches 20 degrees Celsius, the probe is repositioned and melts a path to the contralateral cornu. Sterile saline is injected and second freeze is initiated. Typically 2-4 freezes are conducted. Once all freezes are complete, the cryoprobe is removed. The tenaculum is then removed. Hemostasis of the cervix is achieved. The patient's bladder is emptied and the catheter removed. The speculum is removed.

Description of Post-Service Work: The patient escorted to recovery for observation. Patient and family are counseled. Chart work is completed and operative notes are dictated. There is typically one post-op visit.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	09/2004	
Presenter(s):	George Hill, MD, FACOG; William Peters, MD, FACOG; Sandra Reed, MD, FACOG	
Specialty(s):	American College of Obstetricians and Gynecologists (ACOG)	
CPT Code:	58356	
Sample Size:	75	Resp n: 24      Response: 32.00 %
Sample Type:	Convenience	

	Low	25 <sup>th</sup> pctl	Median*	75th pctl	High
Survey RVW:	3.55	4.63	6.80	9.87	10.78
Pre-Service Evaluation Time:			30		
Pre-Service Positioning Time:			10.0		
Pre-Service Scrub, Dress, Wait Time:			10.0		
Intra-Service Time:	5.00	30.00	45	45.00	60.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
Immed. Post-time:	<u>30.00</u>				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>18</u>	99238x .5	99239x 0.00		
Office time/visit(s):	<u>23.0</u>	99211x 0.0	12x 0.0	13x 1.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
58563	000	6.16

CPT Descriptor Hysteroscopy, surgical with endometrial ablation (eg endometrial resection, electro-surgical ablation, thermoablation)

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
46260	090	6.36

CPT Descriptor 1 Hemorrhoidectomy, internal and external, complex or extensive

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
43268	000	7.38

CPT Descriptor 2 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
58353	010	3.55

CPT Descriptor Endometrial ablation thermal, without hysteroscopic guidance

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11      % of respondents: 45.8 %

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 58356</u>	<u>Key Reference CPT Code: 58563</u>
Median Pre-Service Time	60.00	40.00
Median Intra-Service Time	45	60.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	18	0.00
Median Office Visit Time	23.0	0.00
Median Total Time	176	130.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.79	3.79
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.58	3.54
Urgency of medical decision making	3.17	3.17

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.38	3.88
Physical effort required	3.96	3.50

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.21	3.38
Outcome depends on the skill and judgment of physician	4.29	3.67
Estimated risk of malpractice suit with poor outcome	3.58	3.50

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.54	3.38
Intra-Service intensity/complexity	4.13	3.83
Post-Service intensity/complexity	3.46	3.25

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*



**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value.

	A	B	C	D
2			CPT Code - 58356	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Endometrial cryoablation with ultrasonic guidance excluding endometrial curettage when performed (Do not report 5835X in conjunction with 58100, 58120, 58340, 58350, 78450)	
4	LOCATION		Non Facility	Facility
5	GLOBAL PERIOD		10	10
6	TOTAL CLINICAL LABOR TIME		177.0	72.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME		18.0	30.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		123.0	6.0
9	TOTAL POST-SERV CLINICAL LABOR TIME		36.0	36.0
10	<del>PRE-SERVICE PERIOD</del>			
11	Start: Following visit when decision for surgery or procedure made			
12	Complete pre-service diagnostic & referral forms	L037D	5	5
13	Coordinate pre-surgery services	L037D	3	10
14	Schedule space and equipment in facility	L037D	0	5
15	Provide pre-service education/obtain consent	L037D	7	7
16	Follow-up phone calls & prescriptions	L037D	3	3
17	Other Clinical Activity (please specify)			
18	End: When patient enters office/facility for surgery/procedure			
19	<del>SERVICE PERIOD</del>			
20	Start: When patient enters office/facility for surgery/procedure			
21	Pre-service services			
22	Review charts	L037D	3	
23	Greet patient and provide gowning	L037D	3	
24	Obtain vital signs	L037D	5	
25	Provide pre-service education/obtain consent			
26	Prepare room, equipment, supplies	L037D	2	
27	Setup scope (non facility setting only)			
28	Prepare and position patient/ monitor patient/ set up IV	L037D	2	
29	Sedate/apply anesthesia			
30	Intra-service			
31	Assist physician in performing procedure	L037D	45	
32	Assist physician in performing procedure	L051B	45	
33	Assist physician in performing procedure			
34	Post-Service			
35	Monitor pt. following service/check tubes, monitors, drains			
36	Clean room/equipment by physician staff	L037D	3	
37	Clean Scope			
38	Clean Surgical Instrument Package	L037D	15	
39	Complete diagnostic forms, lab & X-ray requisitions			
40	Review/read X-ray, lab, and pathology reports			
41	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			
42	Discharge day management 99238 --12 minutes 99239 --15 minutes	L037D		6
43	Other Clinical Activity (please specify)			
44	End: Patient leaves office			
45	<del>POST-SERVICE PERIOD</del>			
46	Start: Patient leaves office/facility			
47	Conduct phone calls/call in prescriptions			
48	Office visits: Greet patient, escort to room, provide gowning, interval history & vital signs and chart, assemble previous test reports/results, assist physician during exam, assist with dressings, wound care, suture removal, prepare dx test, prescription forms, post service education, instruction, counseling, clean room/equip, check supplies, coordinate home or outpatient care			
49	List Number and Level of Office Visits			
50	99211 16 minutes		16	
51	99212 27 minutes		27	
52	99213 38 minutes		36	1
53	99214 53 minutes		53	
54	99215 63 minutes		63	
55	Other			
56				
57	Total Office Visit Time		36	38
58	Other Activity (please specify)			
59	End: with last office visit before end of global period			

	A	B	C	D
2			CPT Code - 58356	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Endometrial cryoablation with ultrasonic guidance including endometrial curettage when performed (Do not report 5835X in conjunction with 58100, 58120, 58340, 78700, 78850)	
4	LOCATION		Non Facility	Facility
80	MEDICAL SUPPLIES			
81	PEAC multispecialty supply package	SA048	2	1
82	Post-op incision care kit			
83	Endometrial cryoablation disposable probe - invoice attached		1	
84	Foley catheter	SD024	1	
85	10cc Luer-lock syringe for paracervical block	SC051	1	
86	20cc non-Luer lock syringe for saline	SC053	1	
87	Sterile saline	CMS database	50cc	
88	Ultrasound gel	SJ062	60	
89	Topical cervical anesthesia (lidocaine 4% soln, topical)	SH050	20 cc	
90	4x4 sterile gauze, 10 pack	SG056	1	
91	Endometrial curette	SD039	1	
92	Alcohol wipes	SM021	5	
93	needle, spinal	SC028	1	
94	Betadine or other topical antiseptic	SJ042	100 ml	
95	sterile gloves	SB024	2	
96	eye shield	SB038	1	
97	surgical masks	SB033	3	
98	25% bupivacaine	SH021	20 cc	
99	Pelvic exam pack	SA051	2	1
100	Instrument cleaning supplies	SA043	1	
101	Equipment			
102	Basic Surgical Instrument Package \$500			
103	Medium Surgical Instrument Package \$1,500	E72006	1	
104	Ultrasound machine with abdominal transducer	E52001	26	
105	Cryoablation machine -see invoice for per use fee		1 use	
106	Electncal examination table with knee supporting stirrups	E 11003	26	
107	Fiberoptic examination light	E 11006	26	
108				
109				
110				

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

October 2004

**Doppler Velocimetry, Umbilical and Middle Cerebral Arteries**

CPT created two new codes to describe doppler velocimetry of fetal umbilical artery and middle cerebral artery. These are codes that are needed to describe the work involved in adequately assessing and timing the delivery of a growth restricted fetus. These procedures are typically performed by physicians, not clinical staff.

Code 76820 Doppler velocimetry; umbilical artery

The RUC agreed that the median RVU of 0.50 was appropriate for code 76820 *Doppler velocimetry; umbilical artery*. The RUC reviewed the survey data and the comparison with the reference code 76827 *Echo exam of fetal heart* (Work RVU=0.58). Given a slightly lower total time and intensity the RUC agreed that a work RVU of 0.50 would place the code in proper rank order with similar codes such as the reference code. **The RUC recommends a work RVU of 0.50 for code 76820.**

Code 76821 Doppler velocimetry, fetal; middle cerebral artery

The RUC discussed code 76821 *Doppler velocimetry, fetal; middle cerebral artery* in much greater detail. The RUC was concerned that the survey results indicated that the time and intensity measures would indicate a value the same as 76820, however, the presenters recommended a higher value at the 75<sup>th</sup> percentile value. The presenters explained that the survey results that were based on responses from radiologists and maternal fetal medicine physicians may have resulted in an anomaly. The presenters explained that the procedure is performed 90% of the time by maternal fetal medicine physicians and 10% of the time by radiologists. However, the majority of the survey respondents were radiologists and the presenters felt that the survey data by the radiologists skewed the overall survey responses. Since the maternal fetal medicine physicians will be providing the vast majority of the services, the RUC agreed with the presenters that it would be appropriate to give greater weight to the maternal medicine survey data that resulted in a median RVU of 0.70. The presenters assured the committee that physicians and not clinical staff will be performing the procedure. The committee also felt that this value of 0.70 would place the code in proper rank order with 76820 *doppler velocimetry, fetal; umbilical artery* (recommended work RVU = 0.50) The presenters explained that there is a significant difference between Doppler velocimeter of the umbilical artery and the middle cerebral artery and a 0.20 RVU difference is warranted. Due to the anomalies in the data from the two societies the RUC agreed that the practice pattern of the maternal fetal medicine physician was appropriate. It is likely that radiologists who valued the code considered they were performing this examination in conjunction with another obstetrical ultrasound examination such as 76811 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal*

evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation (work RVU =1.90) and 76805 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation (work RVU = 0.99) In contrast, when maternal fetal medicine physicians perform 76821, it will typically be performed as a stand alone code.

**The RUC recommends a work RVU of 0.70 for code 76821.**

The committee also made several adjustments to the practice expense inputs such as changing the staff type to the standard staff blend of RN/LPN/MT and specifying that code 76820 uses an ultrasound room and 76821 uses an ultrasound color Doppler. The details of the practice expense inputs are attached to the recommendations.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲ 76827		Doppler echocardiography, fetal, <del>cardiovascular system,</del> pulsed wave and/or continuous wave with spectral display; complete	XXX	0.58 (No Change)
76828		<i>follow-up or repeat study</i> <i>(To report the use of color mapping, use 93325)</i>	XXX	0.56 (No Change)
● 76820	AQ1	Doppler velocimetry, fetal; umbilical artery	XXX	0.50
● 76821	AQ2	middle cerebral artery	XXX	0.70

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:76820 Tracking Number: AQ1 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: .50

**RUC RVU: 0.50**

CPT Descriptor: Doppler velocimetry fetal; umbilical artery

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 23 year old female is referred for evaluation of uterine size less than dates. Her current gestational age is 32 weeks. Review of her history demonstrates a certain last menstrual period confirmed by a 10 week ultrasound performed at the time of her first prenatal visit. Uterine size had been consistent with menstrual dates up until approximately 20 weeks. Since that time there has been a progressive lag in uterine size as compared to her known menstrual age. An obstetrical ultrasound examination is performed. That study demonstrates composite fetal measurements consistent with 29 weeks and significant head/abdomen circumference discrepancy suggesting asymmetric fetal growth retardation. The amniotic fluid volume is normal. Doppler velocimetry of the umbilical artery is performed to further evaluate fetal well-being and determine the need for further intervention.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- review prenatal records
- review previous ultrasound reports and/or films

## Description of Intra-Service Work:

- visualize segment of umbilical cord
- duplex Doppler sampling gate is placed over a portion of an umbilical artery almost perpendicular to the axis of the gate
- adjust gain and filters to ensure adequate recording of diastolic flow
- record 2-4 waveforms during period when fetus is inactive and fetal breathing is absent
- use electronic calipers to measure peak systolic and end diastolic frequency shift
- calculate one of several commonly used indices
- average the results of 2-4 waveforms and compare to gestational age specific normal values

## Description of Post-Service Work:

- inform patient of results
- convey abnormal results to referring physician
- prepare written report

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	09/2004	
<b>Presenter(s):</b>	James T. Christmas, MD; George A. Hill, MD; Sandra B. Reed, MD; Bibb Allen, Jr., MD; Jonathan Berlin, MD	
<b>Specialty(s):</b>	The American College of Obstetricians and Gynecologists; Society for Maternal-Fetal Medicine; The American College of Radiology	
<b>CPT Code:</b>	76820	
<b>Sample Size:</b>	<b>Resp n:</b> 32	<b>Response:</b> 25.60 %
<b>Sample Type:</b>	Random	

	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW:	0.20	0.39	0.50	0.65	0.95
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	2.00	5.00	10.00	11.25	25.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
Immed. Post-time:	<u>5.00</u>				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
76827	XXX	0.58

CPT Descriptor Echo exam of fetal heart

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
97110	XXX	.45

CPT Descriptor 1 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99311	XXX	.6

CPT Descriptor 2 Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
---------------------------------	---------------	-----------------

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose **Key Reference Code:** 15      **% of respondents:** 46.8 %

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code:</u> 76820	<u>Key Reference CPT Code:</u> 76827
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	10.00	18.00
Median Immediate Post-service Time	5.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	20.00	18.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.25	3.73
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.19	3.73
Urgency of medical decision making	3.44	3.73

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.41	3.00
Physical effort required	3.03	3.13
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	3.34	3.67
Outcome depends on the skill and judgment of physician	3.47	4.13
Estimated risk of malpractice suit with poor outcome	3.84	4.07

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.39	2.73
Intra-Service intensity/complexity	2.50	3.67
Post-Service intensity/complexity	3.03	3.00

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American College of Obstetricians and Gynecologists (ACOG) and the American College of Radiology (ACR) convened their RUC panels to review survey data for CPT code 7682X1. ACOG invited an ACOG Fellow with direct practice experience with this procedure to participate in the development of recommendations. After convening separately, representatives of the two panels met to finalize this proposal.



If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Ob/Gyn	Frequency 45000	Percentage	%
Specialty Radiology	Frequency 5000	Percentage	%
Specialty	Frequency 0	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 30  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Ob/Gyn	Frequency 25	Percentage	%
Specialty Radiology	Frequency 5	Percentage	%
Specialty	Frequency 0	Percentage	%

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:76821 Tracking Number: AQ2 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: 0.70

RUC RVU: 0.70

CPT Descriptor: Doppler velocimetry fetal; middle cerebral artery

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: The patient is a 25 y.o. G3P1Ab1 who became Rh-D sensitized when she did not receive Rhesus immune globulin at the time of a spontaneous miscarriage in her first pregnancy. In her second pregnancy she had minimal elevation of anti-D titers. In the current (third) pregnancy, the patient's initial antibody screen at 20 weeks' gestation revealed an anti-D titer of 1:128. Middle cerebral artery Doppler studies are performed at 22 weeks gestation in order to assess the risk of ongoing anemia and need for further intervention.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

## Description of Pre-Service Work:

- review of prenatal records
- review of laboratory data
- review of previous ultrasound reports and/or films

## Description of Intra-Service Work:

- real time ultrasound to locate fetal head
- identify the anterior wing of the sphenoid bone
- use color flow Doppler to image the Circle of Willis
- place a pulsed Doppler gate over the middle cerebral artery near its origin from the Circle of Willis
- adjust transducer probe orientation or gate orientation to ensure angle of insonance is close to zero degrees
- obtain 2-4 measurements and record the highest velocity
- compare peak systolic velocity to published gestational age - specific norms

## Description of Post-Service Work:

- inform patient of results
- communicate results, recommendations to referring physician
- prepare and sign written report

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	09/2004		
Presenter(s):	George Hill, MD; James T. Christmas, MD; Sandra Reed, MD; Bibb Allen, Jr., MD; Jonathan Berlin, MD		
Specialty(s):	American College of Obstetricians and Gynecologists, American College of Radiology, Society of Maternal-Fetal Medicine		
CPT Code:	76821		
Sample Size:	125	Resp n:	32
		Response:	25.60 %
Sample Type:	Random		

	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Survey RVW:	0.20	0.30	0.55	0.70	1.50
Pre-Service Evaluation Time:			5.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	2.00	5.00	10.00	15.00	25.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
Immed. Post-time:	<u>5.00</u>				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
76827	XXX	0.58

CPT Descriptor Echo exam of fetal heart

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
92012	XXX	.67

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
20610	000	.79

CPT Descriptor 2 Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
	010	

CPT Descriptor

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17      % of respondents: 53.1 %

**TIME ESTIMATES (Median)**

	<u>New/Revised CPT Code: 76821</u>	<u>Key Reference CPT Code: 76827</u>
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	10.00	18.00
Median Immediate Post-service Time	5.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	20.00	18.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.19	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.06	3.82
Urgency of medical decision making	3.59	3.59

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.69	3.65
Physical effort required	3.34	3.12

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.56	3.53
Outcome depends on the skill and judgment of physician	3.58	4.47
Estimated risk of malpractice suit with poor outcome	3.90	4.06

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.71	3.18
Intra-Service intensity/complexity	2.50	3.71
Post-Service intensity/complexity	3.03	3.18

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 76827 – Doppler echocardiography, fetal, cardiovascular system, pulsed wave and/or continuous wave with spectral display, complete  
 76828 – follow-up or repeat study  
 76815 – transabdominal obstetric ultrasound, limited

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ob/Gyn	How often? Rarely
Specialty Radiology	How often? Rarely
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5000  
 If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty Ob/Gyn	Frequency 4500	Percentage 90.00 %
Specialty Radiology	Frequency 500	Percentage 10.00 %
Specialty	Frequency 0	Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 20  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Ob/Gyn	Frequency 18	Percentage 90.00 %
Specialty Radiology	Frequency 2	Percentage 10.00 %
Specialty	Frequency 0	Percentage %

Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value.

	A	B	C	D
1			76820	76821
2	Doppler Velocimetry	CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Doppler velocimetry, fetal; umbilical artery	Doppler velocimetry, fetal; middle cerebral artery
3	LOCATION		In Office	In Office
4	GLOBAL PERIOD		XXX	XXX
5	TOTAL CLINICAL LABOR TIME		10	34
6	TOTAL PRE-SERV CLINICAL LABOR TIME			5
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		10	22
8	TOTAL POST-SERV CLINICAL LABOR TIME			7
9	PRE-SERVICE PERIOD			
10	Other Clinical Activity			
11	- Pull and hang all related prior imaging studies and hang for MD review	L037D		5
12	SERVICE PERIOD			
13	Start: When patient enters office/facility for surgery/procedure			
14	Pre-service			
15	Greet patient and provide gowning	L037D		3
16	Provide pre-service education/obtain consent	L037D		
17	Prepare room, equipment, supplies	L037D		2
18	Prepare and position patient/ monitor patient/ set up IV	L037D		2
19	Intra-service			
20	Assist physician in performing procedure/ Acquire Images	L037D	10	15
21	Post-Service			
22	Clean room/equipment by physician staff	L037D		3
23	Other Clinical Activity: follow up phone call			
24	- Process films, hang films and review study with interpreting MD prior to patient discharge	L037D		3
25	End: Patient leaves office			
26	POST-SERVICE PERIOD			
27	MEDICAL SUPPLIES			
28	Aquasonic gel	SJ062		60 cc
29	Chux	SB044		1
30	Disinfectant	SM013		10cc
31	Gloves non-sterile	SB022		2
32	Drape, non-sterile sheet, 40 in X 60 in	SB006		1
33	Film, 14x17, laser	SK034	2	2
34	Film jacket or jacket insert	SK091		1
35	Patient gown, disposable	SB026		1
36	sanitizing wipes (patient)	SM021		2
37	Table paper			7 ft.
38	Equipment			
39	Ultrasound room	E52018		22
40	Pentium Computer	E52003		
41	Review station	E52013		
43	Stretcher	E11002		
44	Sony color video printer	E52010		
45	digital acquisition unit	E52007		
	Acuson Sequoia C0256	E52020		
	Ultrasound Color Doppler	E52001	10	

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations  
October 2004

**Flow Cytometry**

The number of clinical flow cytometric applications has grown significantly in the past few years, as has the number of antibodies used to evaluate hematologic conditions. In response to this growth and concerns of the Centers for Medicare and Medicaid Services, the CPT Editorial Panel in May 2004 further clarified its flow cytometric section by deleting one code and adding five. This revision separated the work between the laboratory technologist and the physician. Two of the five new codes involve the technical component of morphologic correlation, and the three other codes involve the physician interpretation of flow cytometry.

The RUC understands that new coding structure for flow cytometry (CPT codes 88184-88189) will result in an overall savings. We request that CMS consider these savings, much like you often consider budget increases for CPT codes which represent unbundled services. This savings should be considered to offset other increases resulting from coding changes and refinements to one of the components of the RBRVS. If the savings for this new coding structure for flow cytometry are greater than the increases for other coding changes or relative value refinements, a positive adjustment should be made to the conversion factor.

The RUC reviewed the specialty society physician work recommendations for flow cytometry codes:

**88187** *Flow cytometry, interpretation; 2 to 8 markers*

**88188** *Flow cytometry, interpretation; 9 to 15 markers*

**88189** *Flow cytometry, interpretation; 16 or more markers*

The RUC reviewed the specialty recommended reference codes and the pre, intra, and post physician time for the family of new codes, in developing its recommendation. The RUC first reviewed the specialty's reference codes: 88331 *Pathology consultation during surgery; first tissue block, with frozen section (s), single specimen* (Work RVU = 1.19); 88307 *Surgical pathology, gross and*

*microscopic examination, Level V (Work RVU = 1.59); 88325 Consultation, comprehensive, with review of records and specimens, with report on referred material (Work RVU = 2.22), in relation to the new codes in terms of physician time and work.*

The RUC then discussed the specialty recommendation in detail, and agreed with the physician time and the descriptions of work in the intra-service time period for all the codes. However the pre and post service physician work time needed adjustment to represent the typical patient. The pre-service time was determined by the RUC and the specialty to be typically identical for each of the codes (5 minutes). These five minutes would include discussing the potential analysis with the clinician and other professionals prior to the receipt of the specimen. The RUC recommendation for code 88189 was then appropriately adjusted for this change in time.

In addition, the post-service time in the survey results was believed to be overstated by the survey respondents. The RUC and the specialty believed that the post-service physician time should be lowered to reflect the typical patient encounter. Therefore, by using an intra-work per unit of time methodology used by the RUC, 0.16 RVUs were extracted from the specialty society recommendation for codes 88187 and 88188, reflecting a reduction of 7 minutes of post-service work. 88189 was adjusted for 5 minutes of post-service work to account for the discussion between the pathologist and the clinician. Below are the RUC recommended relative values for codes 88187, 88188, and 88189 with the time changes taken into account.

88187

Specialty Society Recommendation:	1.52
Removal of the equivalent of the work associated with 7 minutes of Post Service Time (7 x 0.0224)	- 0.16
<b>RUC Relative Value Recommendation for 88187</b>	<b>1.36</b>

88188

Specialty Society Recommendation:	1.85
Removal of the equivalent of the work associated with 7 minutes of Post Service Time (7 x 0.024)	- 0.16
<b>RUC Relative Value Recommendation for 88188</b>	<b>1.69</b>

88189

Specialty Society Recommendation:	2.45
Removal of the equivalent of the work	- 0.11

associated with 5 minutes of pre-service Time (5 x 0.0224)	
Removal of the equivalent of the work associated with 5 minutes of post-service Time (5 x 0.0224)	- 0.11
<b>RUC Relative Value Recommendation for 88189</b>	<b>2.23</b>

The amended times for 88187, 88188 and 88189 are as follows:

	88187	88188	88189
Pre-Service Time	5	5	5
Intra-Service Time	30	35	40
Post-Service Time	3	3	5

**Practice Expense:**

The RUC carefully reviewed the attached practice expense recommendations for the technical component of the flow cytometry codes (88184 and 88185) so that there would not be duplication in any clinical labor, medical supplies, or equipment in the non-facility setting. The RUC recommends no practice expense inputs in the facility setting. In addition, there are no practice expense inputs recommended for codes 88187, 88188, and 88189.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
88180		Flow cytometry; each cell surface, cytoplasmic or nuclear marker	XXX	0.36
• 88184	AV1	Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker	XXX	0.00 (No Physician Work)
+ • 88185	AV2	each additional marker	XXX	0.00 (No Physician Work)

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
		<u>(Report 8818X1 in conjunction with 8818X)</u>		
● 88187	AV3	Flow cytometry, interpretation; 2 to 8 markers	XXX	1.36
● 88188	AV4	9 to 15 markers	XXX	1.69
● 88189	AV5	16 or more markers	XXX	2.23

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:88187 Tracking Number: AV3 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: 1.52

RUC RVU: 1.36

CPT Descriptor: Flow cytometry, interpretation; 2 to 8 markers

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 56 year old woman previously diagnosed low grade follicular lymphoma, treated with chemotherapy and in complete remission for one year. The patient develops a new retroperitoneal node, but is otherwise well, with no B symptoms. LDH is normal. FNA of the retroperitoneal lymph node is obtained, and flow cytometry is ordered to confirm suspected relapse.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Discussing the potential analysis with the clinician and other professionals prior to the receipt of the specimen.

Description of Intra-Service Work: Obtaining and reviewing the specimen and analysis order. Retrieve relevant history and diagnostic studies, including examination of previous slides or reports; review of literature or research and communicating with other professionals prior to examination of the specimen. Performing any pertinent gross examination, handling and processing; microscopic examination of an aliquot of the specimen; review of data displays (histograms) from all tubes used for analysis, including redisplay of data when necessary; any required photography or research as necessary to make a final diagnosis; comparison to previous reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature or research during examination; any dictation or report preparation performed during the specimen examination; report proofreading and correction; report sign-out with any concurrent telephone communications with other professionals.

Description of Post-Service Work: Services provided following the sign-out of the analysis of the report including: any written and telephone communications with other professionals, patients and family; obtaining, reviewing, and correlating the results of other diagnostic studies, including examination of other patient information including ancillary reports (eg cytogenetics or molecular diagnostics); arranging for further studies or other services.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>	Susan Spires, MD Gerald Hanson, MD, David Hoak, MD				
<b>Specialty(s):</b>	College of American Pathologists				
<b>CPT Code:</b>	8818X2				
<b>Sample Size:</b>	44	<b>Resp n:</b>	39	<b>Response:</b>	88.63 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.80	1.19	1.52	1.78	4.00
<b>Pre-Service Evaluation Time:</b>			5.0		

Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	10.00	20.00	30.00	34.50	70.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>			
Immed. Post-time:	5.00				
Critical Care time/visit(s):	0.0	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	0.0	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	0.0	99238x 0.00	99239x 0.00		
Office time/visit(s):	0.0	99211x 0.0	12x 0.0	13x 0.0	14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

#### KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
88331	XXX	1.19

CPT Descriptor Pathology consultation during surgery; first tissue block, with frozen section (s), single specimen

#### KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99233	XXX	1.51

CPT Descriptor 1 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.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
92004	XXX	1.67

CPT Descriptor 2 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new-patient, one or more visits

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
88307	XXX	1.59

CPT Descriptor Surgical pathology, gross and microscopic examination, Level V

#### RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.

Number of respondents who choose Key Reference Code: 16      % of respondents: 41.0 %

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code:</u>	<u>Key Reference CPT Code:</u>
	8818X2	88331
Median Pre-Service Time	5.00	0.00

Median Intra-Service Time	30.00	23.00
Median Immediate Post-service Time	5.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	40.00	23.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.38	3.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	2.81
Urgency of medical decision making	3.38	3.94

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.19	3.63
Physical effort required	1.38	1.88

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.75	4.00
Outcome depends on the skill and judgment of physician	4.00	3.88
Estimated risk of malpractice suit with poor outcome	3.47	3.33

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	2.56
Intra-Service intensity/complexity	3.88	3.19
Post-Service intensity/complexity	3.00	2.81

**ADDITIONAL RATIONALE**



Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 15,740 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

### Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:88188 Tracking Number: AV4 Global Period: XXX

**Recommended Work Relative Value**Specialty Society RVU: **1.85**RUC RVU: **1.69**

CPT Descriptor: Flow cytometry, interpretation; 9 to 15 markers

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 49 year old man presents with diffuse lymphadenopathy, but is otherwise asymptomatic. A portion of a lymph node is sent for flow cytometry. Touch imprint shows a very cellular relatively monotonous population of mature lymphoid cells with some nuclear irregularities. A follicular lymphoma is suspected on clinical and morphologic grounds.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Discussing the potential analysis with the clinician and other professionals prior to the receipt of the specimen.

Description of Intra-Service Work: Obtaining and reviewing the specimen and analysis order. Retrieve relevant history and diagnostic studies, including examination of previous slides or reports; review of literature or research and communicating with other professionals prior to examination of the specimen. Performing any pertinent gross examination, handling and processing; microscopic examination of an aliquot of the specimen; review of data displays (histograms) from all tubes used for analysis, including redispays of data when necessary; any required photography or research as necessary to make a final diagnosis; comparison to previous reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature or research during examination; any dictation or report preparation performed during the specimen examination; report proofreading and correction; report sign-out with any concurrent telephone communications with other professionals.

Description of Post-Service Work: Services provided following the sign-out of the analysis of the report including: any written and telephone communications with other professionals, patients and family; obtaining, reviewing, and correlating the results of other diagnostic studies, including examination of other patient information including ancillary reports (eg cytogenetics or molecular diagnostics); arranging for further studies or other services.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>	Susan Spires, MD, Gerald Hanson, MD, David Hoak, MD				
<b>Specialty(s):</b>	College of American Pathologists				
<b>CPT Code:</b>	8818X3				
<b>Sample Size:</b>	44	<b>Resp n:</b>	39	<b>Response:</b>	88.63 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.90	1.59	1.85	2.54	4.50
<b>Pre-Service Evaluation Time:</b>			5.0		

Pre-Service Positioning Time:				0.0		
Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		15.00	30.00	35.00	47.50	85.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
Immed. Post-time:	<u>5.00</u>					
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

#### KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
88307	XXX	1.59

CPT Descriptor Surgical pathology, gross and microscopic examination, Level V

#### KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99215	XXX	1.77

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
71275	XXX	1.92

CPT Descriptor 2 Computed tomographic angiography, chest, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
85097	XXX	0.94

CPT Descriptor Bone Marrow, smear interpretation

#### RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24      % of respondents: 61.5 %

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 8818X3	Key Reference CPT Code: 88307
--------------------------------	------------------------------------	-------------------------------------

Median Pre-Service Time	5.00	0.00
-------------------------	------	------

Median Intra-Service Time	35.00	48.00
Median Immediate Post-service Time	5.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	45.00	48.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.96	3.33
Urgency of medical decision making	3.71	3.29

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.25	3.79
Physical effort required	1.50	2.04
<b><u>Psychological Stress (Mean)</u></b>		
The risk of significant complications, morbidity and/or mortality	4.08	3.62
Outcome depends on the skill and judgment of physician	4.42	3.88
Estimated risk of malpractice suit with poor outcome	4.04	3.71

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.88	2.54
Intra-Service intensity/complexity	4.08	3.67
Post-Service intensity/complexity	3.08	2.70

**ADDITIONAL RATIONALE**



Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 21,840 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? Yes

---

### Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:88189 Tracking Number: AV5 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: 2.45

RUC RVU: 2.23

CPT Descriptor: Flow cytometry, interpretation; 16 or more markers

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: 35 year old female presents with petechiae. CBC shows pancytopenia. The blood smear evaluation show "blast" cells. Flow cytometry immunophenotyping is performed to diagnose and correctly classify the leukemia. The blasts had no morphologic features to suggest specific lineage.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Discussing the potential analysis with the clinician and other professionals prior to the receipt of the specimen.

Description of Intra-Service Work: Obtaining and reviewing the specimen and analysis order. Retrieve relevant history and diagnostic studies, including examination of previous slides or reports; review of literature or research and communicating with other professionals prior to examination of the specimen. Performing any pertinent gross examination, handling and processing; microscopic examination of an aliquot of the specimen; review of data displays (histograms) from all tubes used for analysis, including redispays of data when necessary; any required photography or research as necessary to make a final diagnosis; comparison to previous reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature or research during examination; any dictation or report preparation performed during the specimen examination; report proofreading and correction; report sign-out with any concurrent telephone communications with other professionals.

Description of Post-Service Work: Services provided following the sign-out of the analysis of the report including: any written and telephone communications with other professionals, patients and family; obtaining, reviewing, and correlating the results of other diagnostic studies, including examination of other patient information including ancillary reports (eg cytogenetics or molecular diagnostics); arranging for further studies or other services.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>	Susan Spires, MD, Gerald Hanson, MD, David Hoak, MD				
<b>Specialty(s):</b>	College of American Pathologists				
<b>CPT Code:</b>	8818X4				
<b>Sample Size:</b>	44	<b>Resp n:</b>	39	<b>Response:</b>	88.63 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.94	1.67	2.45	3.20	6.00
<b>Pre-Service Evaluation Time:</b>			5.00		
<b>Pre-Service Positioning Time:</b>			0.0		

Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		20.00	36.50	40.00	55.00	95.00
Post-Service	Total Min:**	CPT code / # of visits				
Immed. Post-time:	5.00					
Critical Care time/visit(s):	0.0	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	0.0	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	0.0	99238x 0.00	99239x 0.00			
Office time/visit(s):	0.0	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

#### KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
88325	XXX	2.22

CPT Descriptor Consultation, comprehensive, with review of records and specimens, with report on referred material

#### KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
99222	XXX	2.14

CPT Descriptor 1 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.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99244	XXX	2.58

CPT Descriptor 2 Office consultation for a new or established 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 moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
88307	XXX	1.59

CPT Descriptor Surgical pathology, gross and microscopic examination, Level V

#### RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 19      % of respondents: 48.7 %

**TIME ESTIMATES (Median)****New/Revised  
CPT Code:  
8818X4****Key Reference  
CPT Code:  
88325**

Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	40.00	69.00
Median Immediate Post-service Time	5.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	50.00	69.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.63	3.95
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.63	4.21
Urgency of medical decision making	4.47	3.53

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.89	3.68
--------------------------	------	------

Physical effort required	1.68	1.74
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.84	3.84
---	------	------

Outcome depends on the skill and judgment of physician	4.84	4.16
--	------	------

Estimated risk of malpractice suit with poor outcome	4.26	3.32
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.47	2.84
----------------------------------	------	------

Intra-Service intensity/complexity	4.78	3.72
------------------------------------	------	------

Post-Service intensity/complexity	3.63	2.79
-----------------------------------	------	------

---

## ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by CAP's relative value workgroup which includes the American Society of Cytopathology (ASC) RUC advisor, representatives of the general pathology community, and members who perform flow cytometry. Additional pathologists with extensive flow cytometry expertise also participated in this review. The workgroup chose to recommend the median survey RVW of 2.45. While the survey time is slightly less than the RUC time for the reference code (60 minutes 88189, 69 minutes 88325) the median RVW recommendation is supported by the substantially greater intensity and complexity of the service as reported by the survey respondents in comparison to the reference code which has an RVW of 2.22

---

## SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain) This professional component code will be reported once together with technical service only codes for flow cytometry. The technical service only codes do not include any physician time or work RVUs.

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
- 

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 88180

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology                      How often? Commonly

Specialty                                      How often?

Specialty                                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 262000

If the recommendation is from multiplee the frequency and percentage for eachcecialty

Frequency 0

Percentage 0.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 52,400 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	88184 Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker.		88185 each additional marker.	
		Non Facility	Facility	Non Facility	Facility
<b>LOCATION</b>					
<b>GLOBAL PERIOD</b>		XXX		XXX	
<b>TOTAL CLINICAL LABOR TIME</b>	L033A-LabTech	80-69		47-7	
<b>TOTAL PRE-SERV CLINICAL LABOR TIME</b>	L033A	7		0	
<b>TOTAL SERVICE PERIOD CLINICAL LABOR TIME</b>	L033A	64-50		46-6	
<b>TOTAL POST-SERV CLINICAL LABOR TIME</b>	L033A	12		1	
<b>PRE-SERVICE</b>					
<b>Start: When containers/requisitions prepared for physician</b>					
Accession specimen/prepare for examination	L033A	5		NA	
Other Clinical Activity (please specify): Print out or pull previous reports from file	L033A	2		NA	
<b>SERVICE PERIOD</b>					
<b>Start: When specimen is ready for examination by pathologist</b>					
Run CBC, prepare cytospin or smear, stain, cover slip, examine under microscope for quality.	L033A	45-10		NA	
Prepare specimen for manual/automated processing.	L033A	20-15		8-3	
Instrument start-up, quality control functions, calibration, centrifugation, maintaining specimen tracking, logs and labeling	L033A	15		NA	
Other Clinical Activity (please specify) Load specimen into flow cytometer, run specimen, monitor data acquisition, and unload flow cytometer	L033A	7		7-2	
Printout histograms and deliver with slides and paperwork to pathologists.	L033A	3-2		NA	
Other Activity (please specify): Review histograms and gating with pathologists.	L033A	1		1	
<b>POST-SERVICE Period</b>					
<b>Start: When specimen examination by pathologist is complete</b>					
Prepare, pack and transport specimens and records for in-house storage and external storage (where applicable)	L033A	3		NA	
Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	2		NA	
Clean room/equipment following procedure (including any equipment maintenance that must be done after the procedure)	L033A	2		NA	
Other Activity (please specify) Enter data into laboratory information system	L033A	5		1	
<b>End: When specimen, chemical waste and record handling is complete</b>					
<b>MEDICAL SUPPLIES</b>					
gloves, non-sterile	SB022	3 pair		NA	
antibody FITC monoclonal conjugate (each test)	SL010	1		1	
calibration beads (each test)	SL021	4 drops		NA	
centrifuge tube	SL024	4		4	
cover slip, glass	SL030	1		NA	
Isoton II diluent	SL084	5 ml		5 ml	
lysing reagent (FACS)	SL089	14 ml		14 ml	
mounting media (Histomount)	SL095	0.2 ml		NA	
paraformaldehyde	SL099	0.5 ml		0.5 ml	
phosphate buffered saline solution	SL107	20 ml		20 ml	
pipette tip (blue-yellow)	SL110	2		2	
slide, microscope	SL122	1		NA	
stain, Wright's soln	SL141	0.3 ml		NA	
<b>PROCEDURE SPECIFIC EQUIPMENT</b>					
differential analyzer, hematology	CMS Database	1		NA	
microscope, compound	E13601	1		NA	
flow cytometer	E13616	1		1	
vortex mixer	E13648	1		NA	
centrifuge	E13656	1		NA	

LOCATION	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	88184 Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker.		88185 each additional marker.	
		Non Facility	Facility	Non Facility	Facility
pipettor (VRW* Catalog #40000-200, \$520)		4		4	
cytospin cytocentrifuge (Thermo Electron Corporation)		1		NA	
* VWR – VWR Scientific Products, 3000 Hadley Road, South Plainfield, NJ 07080, (800) 932-5000, <a href="http://www.vwrsp.com">www.vwrsp.com</a>					
Thermo Electron Corporation, 800-986-9731					
<a href="http://www.thermo.com">www.thermo.com</a>					

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

October 2004

**In Situ Hybridization and Immunohistochemistry Procedures**

Fluorescent in situ hybridization (FISH) has rapidly gained acceptance in the pathology and oncology communities as a definitive diagnostic marker for certain cancers. In response to this gained acceptance, the Centers for Medicare and Medicaid Services and specialty societies sought clarity in the coding structure. The CPT Editorial Panel created two new codes and revised one code, in order to provide further specificity in these FISH procedures. The panel also revised a code and added a code for Immunohistochemistry (IHC) procedures to clarify whether the procedure is performed manually or with the assistance of a computer.

The RUC had the opportunity to have a detailed discussion of the entire set of FISH and ICH procedures, independently and as a group, concerning the physician work and intensity. RUC members understood from the specialty society representatives that the FISH procedures are not billed together.

**88361**

The RUC reviewed the RUC action from April 2003 for code 88361 *Morphometric analysis; tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative* (Work RVU = 0.94). In April 2003, CAP received 17 responses to its survey for 88361 and recommended 1.35 Work RVUs. The RUC believed the survey response rate was too low and made no recommendation. The RUC believed that the more current survey results (with 32 respondents) were more reliable and represented the typical physician work, but only at the 25<sup>th</sup> percentile Work RVU of 1.18. The RUC also reviewed the specialty's key reference code 88112 *Cytopathology, selective cellular enhancement techniques with interpretation (eg, liquid based slide preparation method), except cervical or vaginal* (Work RVU 1.18), and believed it was similar work. **The RUC recommends a relative work value of 1.18 for revised code 88361 *Morphometric analysis; tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology.***

### **88360**

Similar to code 88361, code 88360 *Morphometric analysis; tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual* was reviewed in detail, and it was agreed that the 25<sup>th</sup> percentile more accurately reflected intensity associated with the physician work involved. The RUC believed that the survey results were accurate, but did not believe the work was greater than the specialty's MPC reference code 78494 *Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing* (Work RVU = 1.19). **The RUC recommends a relative work value of 1.10 for code 88360.**

### **88365**

The RUC viewed code 88365 *In situ hybridization (eg, FISH), each probe* as having a physician work intensity equal to code 88361. The RUC believed however, after clarification from the specialty, that the survey median work RVU was appropriate, and the work was similar to its reference code, 78494 *Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing* (Work RVU = 1.19). **The RUC recommends the specialty's median survey results representing a relative work value of 1.20 for code 88365.**

### **88367**

Code 88367 *Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), each probe; using computer-assisted technology* was considered by the RUC to be much more intensive and time consuming for the physician in relation to the other codes in the family discussed above. In addition, the RUC believed the physician work was between the specialty's chosen MPC reference code, 74160 *Computed tomography, abdomen; with contrast material(s)* (Work RVU = 1.27) and the median survey results of 1.35 work RVUs. **The RUC recommends a relative work value of 1.30 for code 88367.**

### **88368**

The specialty and the RUC discussed code 88368 *Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), each probe; manual* in detail regarding the physician intensity. The physician work intensity was agreed to be approximately the same as code 88365, however the procedure is more time consuming. The RUC agreed with the surveyed median physician time of 45 minutes and the work intensity of 88365 to develop its recommendation. **The RUC recommends a relative work value of 1.40 for code 88368.**



The RUC and the specialty also understood that the survey results indicated that there was no physician work associated with the pre-service and post-service time period for any of the codes. Therefore, **the RUC recommends that the RUC exclude the pre-service and post-service physician work descriptions in the RUC database.**

**Practice Expense Inputs**

The RUC reviewed the inputs line by line, and made revisions in the clinical labor time to reflect the typical patient. **The RUC recommends the attached practice expense inputs for this family of codes.**

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲88361	AW1	<u>Morphometric analysis</u> , tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; <u>using computer-assisted technology</u>	XXX	1.18
●88360	AW2	manual	XXX	1.10
▲88365	AW3	<u>Tissue In situ hybridization (eg, FISH), interpretation and report each probe</u>  <u>(Do not report 88365 in conjunction with 88367 or 88368 for the same probe)</u>	XXX	1.20
●88367	AW4	Morphometric analysis, in situ hybridization, (quantitative or semi-quantitative) each probe; using computer-assisted technology	XXX	1.30
●88368	AW5	manual	XXX	1.40

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
88342		<i>Immunohistochemistry (including tissue immunoperoxidase), each antibody</i>  <u>(Do not report 88342 in conjunction with 88361 or 88360 for the same antibody)</u>  (For quantitative or semiquantitative immunohistochemistry, use 88361 or 88360)	XXX	0.85 (No Change)
88355		<i>Morphometric analysis; skeletal muscle</i>	XXX	1.85 (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:88360 Tracking Number: AW2 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: 1.20

RUC RVU: 1.10

CPT Descriptor: Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 54 year old female has previously been diagnosed with ductal carcinoma of the breast with axillary nodal metastasis identified on sentinel lymph node biopsy. The stained slides are analyzed by the pathologist, along with reference positive and negative samples, to determine if the staining process is interpretable and therefore warrants a semiquantitative or quantitative interpretation. The immunoassay is positive and estrogen receptor evaluation is performed. A semiquantitative or quantitative interpretation is manually provided.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Deleted as recommended by the RUC.

Description of Intra-Service Work: Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to reporting of the test results; evaluation of positive and negative immunohistochemical control slides; interpretation of the immunohistochemically stained slides to determine if a semiquantitative/quantitative procedure can be accurately performed, is warranted and needed; semiquantitative/quantitative interpretation of the estrogen receptor preparation; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature of research during examination of the test results; any dictation or report preparation performed during examination of the test results; report proofreading and correction; report sign-out with any concurrent telephone communications with other professionals.

Description of Post-Service Work: Deleted as recommended by the RUC.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>	Susan Spires, MD, Elizabeth Hammond, MD, David Hoak, MD				
<b>Specialty(s):</b>	College of American Pathologists and the American Society of Cytopathology				
<b>CPT Code:</b>	8836X0				
<b>Sample Size:</b>	55	<b>Resp n:</b>	49	<b>Response:</b>	89.09 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.50	1.10	1.20	1.40	3.00
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		

<b>Intra-Service Time:</b>		7.00	21.00	35.00	45.00	65.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
Immed. Post-time:	<u>0.00</u>					
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
88112	XXX	1.18

CPT Descriptor Cytopathology, selective cellular enhancement techniques with interpretation (eg, liquid based slide preparation method), except cervical or vaginal

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
78494	XXX	1.19

CPT Descriptor 1 Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99238	XXX	1.28

CPT Descriptor 2 Hospital discharge day management; 30 minutes or less

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
88331	XXX	1.19

CPT Descriptor Pathology consultation during surgery; first tissue block, with frozen section (s), single specimen

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 16      % of respondents: 32.6 %**

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code:</u> 8836X0	<u>Key Reference CPT Code:</u> 88112
Median Pre-Service Time	0.00	8.00
Median Intra-Service Time	35.00	25.00
Median Immediate Post-service Time	0.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	35.00	43.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.33	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.33
Urgency of medical decision making	3.58	3.42

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	4.00
Physical effort required	2.16	2.00

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.08	4.17
Outcome depends on the skill and judgment of physician	4.17	4.33
Estimated risk of malpractice suit with poor outcome	3.83	4.00

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	1.94	1.81
Intra-Service intensity/complexity	3.75	3.63
Post-Service intensity/complexity	2.75	2.31

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by CAP's relative value workgroup which includes the American Society of Cytopathology (ASC) RUC advisor, representatives of the general pathology community, and members who perform immunohistochemistry services. Additional pathologists with expertise in this field also participated in this review. The workgroup chose to recommend the median survey RVW of 1.20 as the majority of the intensity/complexity measures were higher or comparable to the reference code.



Do many physicians perform this service across the United States? Yes

---

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

**Recommended Work Relative Value**

CPT Code:88361 Tracking Number:

Global Period: XXX

Specialty Society RVU: 1.33

RUC RVU: 1.18

CPT Descriptor: Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 54 year old female has previously been diagnosed with ductal carcinoma of the breast with axillary nodal metastasis identified on sentinel lymph node biopsy. The stained slides are analyzed by the pathologist, along with reference positive and negative samples, to determine if the staining process is interpretable and therefore warrants a semiquantitative or quantitative interpretation. The immunoassay visually shows staining and Her-2/neu evaluation is performed. A semiquantitative or quantitative interpretation is provided using a computer assisted methodology.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Deleted as recommended by the RUC.

Description of Intra-Service Work: Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to reporting of the test results. Initial review of the stained slides to determine if a semiquantitative/quantitative procedure is needed. Evaluation of positive and negative controls of the Her-2/neu preparation; analyze computer digitized images; assess results for accuracy; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature of research during examination of the test results; any dictation or report preparation performed during examination of the test results; report proofreading and correction; report sign-out with any concurrent telephone communications with other professionals.

Description of Post-Service Work: Deleted as recommended by the RUC.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>	Susan Spires, MD, Elizabeth Hammond, MD, David Hoak, MD				
<b>Specialty(s):</b>	College of American Pathologists and the American Society of Cytopathology				
<b>CPT Code:</b>	88361				
<b>Sample Size:</b>	39	<b>Resp n:</b>	32	<b>Response:</b>	82.05 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
<b>Survey RVW:</b>	1.00	1.18	1.33	1.52	4.00
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		

<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.0</b>		
<b>Intra-Service Time:</b>		7.00	23.75	<b>40.00</b>	50.00	155.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u><b>0.00</b></u>					
<b>Critical Care time/visit(s):</b>	<u><b>0.0</b></u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u><b>0.0</b></u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u><b>0.0</b></u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u><b>0.0</b></u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
88112	XXX	1.18

CPT Descriptor Cytopathology, selective cellular enhancement techniques with interpretation (eg, liquid based slide preparation method), except cervical or vaginal

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
74160	XXX	1.27

CPT Descriptor 1 Computed tomography, abdomen; with contrast material(s)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99233	XXX	1.51

CPT Descriptor 2 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: 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.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
88307	XXX	1.59

CPT Descriptor Surgical pathology, gross and microscopic examination, Level V

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10      % of respondents: 31.2 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 88361</u>	<u>Key Reference CPT Code: 88112</u>
Median Pre-Service Time	0.00	8.00
Median Intra-Service Time	40.00	25.00
Median Immediate Post-service Time	0.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
<b>Median Total Time</b>	<b>40.00</b>	<b>43.00</b>
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.20	3.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.30	3.00
Urgency of medical decision making	3.50	3.60

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.20	3.80
Physical effort required	3.10	2.90

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.70	3.90
Outcome depends on the skill and judgment of physician	4.10	4.10
Estimated risk of malpractice suit with poor outcome	3.80	4.00

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.60	2.30
Intra-Service intensity/complexity	3.80	3.50
Post-Service intensity/complexity	3.00	2.70

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, CAP's relative value workgroup which includes the American Society of Cytopathology (ASC) RUC advisor, representatives of the general pathology community, and members who perform immunohistochemistry services. Additional pathologists with expertise in this field also participated in this review. The workgroup selected the median survey RVW of 1.33 as the median survey time for 88361 (40 minutes) is nearly the same as the median RUC time for reference code 88112 (43 minutes) and the intensity/complexity time measures were greater than the reference code.



Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? No

---

### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. The revised 88361 should be crosswalked to the current PLI RVU for 88361.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:88365 Tracking Number: AW3 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: 1.20

RUC RVU: 1.20

CPT Descriptor: In situ hybridization (eg, FISH), each probe

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65 year old male is being evaluated for suspected chronic myelogenous leukemia. His most recent bone marrow biopsy was interpreted as suspicious for a myeloproliferative disorder. Fluorescence in-situ hybridization (FISH) is performed on the bone marrow using a mixture of two DNA probes for BCR and ABL to detect the fusion gene BCR-ABL.

Percentage of Survey Respondents who found Vignette to be Typical: 76%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Deleted as recommended by the RUC.

Description of Intra-Service Work: Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test results; interpretation of the stained slides to determine the appropriate areas of the tumor to evaluate; review and analysis of positive and negative controls; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature of research during examination of the test results; any dictation or documentation performed during examination of the test results. Report preparation and finalization for the stained slides; report proofreading and correction; report sign-out with any concurrent telephone communications with other professionals.

Description of Post-Service Work: Deleted as recommended by the RUC.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)		09/2004			
Presenter(s):	Susan Spires, MD, Elizabeth Hammond, MD, David Hoak MD				
Specialty(s):	College of American Pathologists and the American Society of Cytopathology				
CPT Code:	88365				
Sample Size:	46	Resp n:	41	Response:	89.13 %
Sample Type:	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75th pctl</b>	<b>High</b>
Survey RVW:	0.85	1.05	1.20	1.35	4.00
Pre-Service Evaluation Time:			0.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:	12.00	30.00	40.00	55.00	150.00
Post-Service	Total Min**	CPT code / # of visits			

<b>Immed. Post-time:</b>	<u><b>0.00</b></u>	
<b>Critical Care time/visit(s):</b>	<u><b>0.0</b></u>	99291x 0.0 99292x 0.0
<b>Other Hospital time/visit(s):</b>	<u><b>0.0</b></u>	99231x 0.0 99232x 0.0 99233x 0.0
<b>Discharge Day Mgmt:</b>	<u><b>0.0</b></u>	99238x 0.00 99239x 0.00
<b>Office time/visit(s):</b>	<u><b>0.0</b></u>	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
85097	XXX	0.94

CPT Descriptor Bone Marrow, smear interpretation

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
78494	XXX	1.19

CPT Descriptor 1 Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99238	XXX	1.28

CPT Descriptor 2 Hospital discharge day management; 30 minutes or less

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
88112	XXX	1.18

CPT Descriptor Cytopathology, selective cellular enhancement techniques with interpretation (eg, liquid based slide preparation method), except cervical or vaginal

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

**Number of respondents who choose Key Reference Code: 14      % of respondents: 34.1 %**

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	<u>New/Revised CPT Code: 88365</u>	<u>Key Reference CPT Code: 85097</u>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	40.00	30.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	40.00	30.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.33	3.92
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.58	3.42
Urgency of medical decision making	3.67	3.91

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.75	3.75
Physical effort required	2.50	2.58

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.67	3.67
Outcome depends on the skill and judgment of physician	4.08	4.08
Estimated risk of malpractice suit with poor outcome	3.67	3.83

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.75	2.50
Intra-Service intensity/complexity	4.17	3.67
Post-Service intensity/complexity	2.91	3.17

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by CAP's relative value workgroup which includes the American Society of Cytopathology (ASC) RUC advisor, representatives of the general pathology community, and members who perform in situ hybridization services. Additional pathologists with expertise in this field also participated in this review. The workgroup chose to recommend the median survey RVW of 1.20 as the surveyed time for 88365 (40 minutes) represents 1/3 more time as well as higher intensity/complexity time measures than the reference RUC time of 30 minutes for 85097 which has a RVW of 0.94.



Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%



Do many physicians perform this service across the United States? No

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

**Recommended Work Relative Value**

CPT Code: 88367 Tracking Number: AW4 Global Period: XXX

Specialty Society RVU: 1.35

RUC RVU: 1.30

CPT Descriptor: Morphometric analysis, in situ hybridization, (quantitative or semi-quantitative) each probe; using computer-assisted technology

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 54-year-old woman has previously been diagnosed with invasive ductal carcinoma of the breast with axillary nodal metastasis identified by sentinel lymph node biopsy. Stained slides are analyzed by fluorescence in situ hybridization (FISH) by the pathologist at a FISH workstation, along with reference positive and negative controls, first determining the appropriate areas of the tumor to evaluate and then interpreting the FISH quantifying amplification of the HER2 gene using computer-assisted technology.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Deleted as recommended by the RUC.

Description of Intra-Service Work: Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test results; interpretation of the stained slides to determine the appropriate areas of the tumor to evaluate; review and analysis of positive and negative controls; analyzing the fluorescence in situ hybridization (FISH) quantifying amplification of the HER2 gene using computer-assisted technology; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature of research during examination of the test results; any dictation or documentation performed during examination of the test results. Report preparation and finalization for the stained slides and the Her-2 gene; report proofreading and correction; report sign-out with any concurrent telephone communications with other professionals.

Description of Post-Service Work: Deleted as recommended by the RUC.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>	Susan Spires, MD, Elizabeth Hammond, MD, David Hoak, MD				
<b>Specialty(s):</b>	College of American Pathologists and the American Society of Cytopathology				
<b>CPT Code:</b>	8836X6				
<b>Sample Size:</b>	28	<b>Resp n:</b>	17	<b>Response:</b>	60.71 %
<b>Sample Type:</b>	Panel				
	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
<b>Survey RVW:</b>	0.90	1.19	1.35	1.60	2.70
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		

<b>Intra-Service Time:</b>		12.00	30.00	<b>42.00</b>	55.00	120.00
<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>				
<b>Immed. Post-time:</b>	<u>0.00</u>					
<b>Critical Care time/visit(s):</b>	<u>0.0</u>	99291x 0.0	99292x 0.0			
<b>Other Hospital time/visit(s):</b>	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
<b>Discharge Day Mgmt:</b>	<u>0.0</u>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
88307	XXX	1.59

CPT Descriptor Surgical pathology, gross and microscopic examination, Level V

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
74160	XXX	1.27

CPT Descriptor 1 Computed tomography, abdomen; with contrast material(s)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99233	XXX	1.51

CPT Descriptor 2 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: 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.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
85097	XXX	0.94

CPT Descriptor Bone Marrow, smear interpretation

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose **Key Reference Code: 6**      % of respondents: 35.2 %

**TIME ESTIMATES (Median)**

<u>TIME ESTIMATES (Median)</u>	New/Revised CPT Code: 8836X6	Key Reference CPT Code: 88307
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	42.00	48.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	42.00	48.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.17	3.67
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.50
--	------	------

Urgency of medical decision making	3.50	3.83
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	4.00
--------------------------	------	------

Physical effort required	3.00	3.17
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.83	4.00
---	------	------

Outcome depends on the skill and judgment of physician	4.00	4.33
--	------	------

Estimated risk of malpractice suit with poor outcome	3.83	4.33
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.50	2.50
----------------------------------	------	------

Intra-Service intensity/complexity	4.00	4.17
------------------------------------	------	------

Post-Service intensity/complexity	3.17	3.33
-----------------------------------	------	------

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by CAP's relative value workgroup which includes the American Society of Cytopathology (ASC) RUC advisor, representatives of the general pathology community, and members who perform in situ hybridization services. Additional pathologists with expertise in this field also participated in this review. CAP received 17 responses to the survey for 8836X6 as this code represents new technology that is currently not performed by many physicians. The workgroup chose to recommend the median survey RVW of 1.35 for this service as the surveyed time for 8836X6 (42 minutes) is 12% below the RUC time for the reference code (88307, 48 minutes). The median RVW of the surveyed code represents a proportional reduction in the reference codes RVW. This

recommendation is also consistent with the lower intensity measures for 8836X6 reported by the survey respondents in comparison to the reference code.

**SERVICES REPORTED WITH MULTIPLE CPT CODES**

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- Multiple codes allow flexibility to describe exactly what components the procedure included.
- Multiple codes are used to maintain consistency with similar codes.
- Historical precedents.
- Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The service previously was reported 88358 for morphometric analysis and 88365 for the in situ hybridization preparation.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology                      How often? Rarely

Specialty                                      How often?

Specialty                                      How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2300

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 700

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Do many physicians perform this service across the United States? No

---

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 88368 Tracking Number: AW5 Global Period: XXX

**Recommended Work Relative Value**

Specialty Society RVU: 1.50

RUC RVU: 1.40

CPT Descriptor: Morphometric analysis, in situ hybridization, (quantitative or semi-quantitative) each probe; manual

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 54-year-old woman has previously been diagnosed with invasive ductal carcinoma of the breast with axillary nodal metastasis identified by sentinel lymph node biopsy. Stained slides are analyzed by fluorescence in situ hybridization (FISH) by the pathologist, along with reference positive and negative controls, first determining the appropriate areas of the tumor to evaluate and then manually interpreting the FISH quantifying amplification of the HER2 gene.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Deleted as recommended by the RUC.

Description of Intra-Service Work: Obtaining and reviewing the history and diagnostic studies, including examination of previous study reports; review of literature or research and communicating with other professionals prior to interpretation of the test results; interpretation of the stained slides to determine the appropriate areas of the tumor to evaluate; review and analysis of positive and negative controls; manually analyzing the fluorescence in situ hybridization (FISH) quantifying amplification of the HER2 gene; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; any review of literature of research during examination of the test results; any dictation or documentation performed during examination of the test results. Report preparation and finalization for the stained slides and the Her-2 gene; report proofreading and correction; report sign-out with any concurrent telephone communications with other professionals.

Description of Post-Service Work: Deleted as recommended by the RUC.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		09/2004			
<b>Presenter(s):</b>	Susan Spires, MD, David Hoak, MD, Elizabeth Hammond, MD				
<b>Specialty(s):</b>	College of American Pathologists and the American Society of Cytopathology				
<b>CPT Code:</b>	8836X7				
<b>Sample Size:</b>	46	<b>Resp n:</b>	41	<b>Response:</b>	89.13 %
<b>Sample Type:</b>	Panel				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Survey RVW:</b>	0.80	1.20	1.50	1.60	7.00
<b>Pre-Service Evaluation Time:</b>			0.0		
<b>Pre-Service Positioning Time:</b>			0.0		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			0.0		
<b>Intra-Service Time:</b>	12.00	30.00	45.00	55.00	185.00

<b>Post-Service</b>	<b>Total Min**</b>	<b>CPT code / # of visits</b>
<b>Immed. Post-time:</b>	<b><u>0.00</u></b>	
<b>Critical Care time/visit(s):</b>	<b><u>0.0</u></b>	99291x 0.0 99292x 0.0
<b>Other Hospital time/visit(s):</b>	<b><u>0.0</u></b>	99231x 0.0 99232x 0.0 99233x 0.0
<b>Discharge Day Mgmt:</b>	<b><u>0.0</u></b>	99238x 0.00 99239x 0.00
<b>Office time/visit(s):</b>	<b><u>0.0</u></b>	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (60); 99292 (30); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
88307	XXX	1.59

CPT Descriptor Surgical pathology, gross and microscopic examination, Level V

**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>
78465	XXX	1.46

CPT Descriptor 1 Myocardial perfusion imaging; tomographic (SPECT), multiple studies, at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>
99233	XXX	1.51

CPT Descriptor 2 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: 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.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>
88331	XXX	1.19

CPT Descriptor Pathology consultation during surgery; first tissue block, with frozen section (s), single specimen

**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose **Key Reference Code**: 14      % of respondents: 34.1 %

**TIME ESTIMATES (Median)**

	<b>New/Revised CPT Code: 8836X7</b>	<b>Key Reference CPT Code: 88307</b>
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	45.00	48.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
<b>Median Total Time</b>	<b>45.00</b>	<b>48.00</b>
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.36	4.21
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	3.43
Urgency of medical decision making	3.42	4.00

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.14	3.86
Physical effort required	3.29	2.79

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.64	4.07
Outcome depends on the skill and judgment of physician	4.21	4.43
Estimated risk of malpractice suit with poor outcome	3.57	4.29

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference  
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.57	2.57
Intra-Service intensity/complexity	4.21	4.07
Post-Service intensity/complexity	3.00	3.21

**ADDITIONAL RATIONALE**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by CAP's relative value workgroup which includes the American Society of Cytopathology (ASC) RUC advisor, representatives of the general pathology community, and members who perform in situ hybridization services. Additional pathologists with expertise in this field also participated in this review. The workgroup chose to recommend the median survey RVW of 1.50 for this service as the surveyed time for 8836X7 (45 minutes) is slightly below the RUC time for the reference code (88307, 48 minutes/ RVW 1.59) and comparable intensity/complexity measures.



Specialty

Frequency

Percentage

%

Do many physicians perform this service across the United States? No

---

**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA Specialty Society Recommendation

	A	B	C	D	E	F
1						
2			CPT Code: 88361		CPT Code: 88360	
3		CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE	Code Descriptor: Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology		Code Descriptor: Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual	
4	LOCATION		Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD		XXX		XXX	
6	TOTAL CLINICAL LABOR TIME	L033A/LO37B	74.0	0.0	74.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L033A	2.0	0.0	2.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037B	52.0	0.0	52.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L033A	20.0	0.0	20.0	0.0
10	<b>PRE-SERVICE</b>					
11	Start: When containers/requisitions prepared for physician					
12	Prepare specimen containers/preload fixative/label containers/distribute requisition form(s) to physician					
13	Accession specimen/prepare for examination					
14	Perform screening function (where applicable)					
15	Other Clinical Activity (please specify): Retrieves the blocks and slides for review and selection of the appropriate block for slide preparation for morphometric analysis.	L033A	2		2	
16	End: When specimen is ready for examination by pathologist.					
17	<b>SERVICE PERIOD</b>					
18	Start: When specimen is ready for examination by pathologist					
19	Assist pathologist with gross specimen examination (including performance of intraoperative frozen sections)					
20	Prepare specimen for manual/automated processing	L037B	18		18	
21	Process specimen for slide preparation (includes processing, embedding, sectioning and recuts, centrifugation, routine and special staining, cover slipping, quality control function, maintaining specimen tracking, logs and labeling)	L037B	32		32	
24	Coordinate care					
25	Other Clinical Activity (please specify): Assemble and deliver slides with paperwork to pathologist.	L037B	2		2	
26	End: When specimen examination by pathologist is complete					
27	<b>POST-SERVICE PERIOD</b>					
28	Start: When specimen examination by pathologist is complete					
29	Prepare, pack and transport specimens and records for in-house storage and external storage (where applicable)	L033A	12		12	
30	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	5		5	
31	Clean room/equipment following procedure (including any equipment maintenance that must be done after the procedure)					
32	Manage any relevant utilization review/quality assurance activities and regulatory compliance documentation	L033A	3		3	
33	Submit/receive material for consultation (where applicable)					
34	Other Activity (please specify):					
35	End: When specimen, chemical waste and record handling is complete					
36	Other Activity (please specify)					

AMA Specialty Society Recommendation

	A	B	C	D	E	F
2			<b>CPT Code: 88361</b>		<b>CPT Code: 88360</b>	
3		<b>CMS STAFF TYPE, MED SUPPLY, OR EQUIP CODE</b>	<b>Code Descriptor:</b> Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody, using computer-assisted technology.		<b>Code Descriptor:</b> Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody, manual.	
4	<b>LOCATION</b>		<b>Non Facility</b>	<b>Facility</b>	<b>Non Facility</b>	<b>Facility</b>
37	<b>MEDICAL SUPPLIES</b>					
38	AEC buffer	SL002	2		2	
39	AEC chromogen	SL003	0		0	
40	antibody FITC monoclonal conjugate (each test)	SL010	1		1	
41	background block	SL017	5		5	
42	biotinylated link (mouse, rabbit)	SL019	0		0	
43	blade, microtome	SF004	1		1	
44	cover slip, glass	SL030	7		7	
45	eye shield, splash protection	SM016	1		1	
46	gloves, non-sterile, nitrile	SB023	1		1	
47	gown, staff, impervious	SB027	1		1	
48	hematoxylin reagent	SL077	8		8	
49	label for microscope slides	SL085	7		7	
50	mounting media (Histomount)	SL095	2		2	
51	peroxide block	SL102	50		50	
52	phosphate buffered saline packet (Zeus)	SL106	1		1	
53	positive control slide	SL112	2		2	
54	slide, microscope	SL122	6		6	
55	stain, hematoxylin	SL077	8		8	
56	streptavidin label	SL142	0		0	
57	tissue revival soln	SL145	50		50	
58						
59	<b>Equipment</b>					
60	microscope, compound	E13601	1		1	
61	microtome	E13618	1		1	
62	robotic cover slipper	E13642	1		1	
63	slide dryer oven	E13644	1		1	
64	slide etcher	E13645	1		1	
65	solvent recycling system	E13646	1		1	
66	ventilator hood & blower	E91003	1		1	
67	decloaking chamber (DC2002)	CMS	1		1	
68	differential counter, hematology	CMS			1	
69	DNA image analyzer (ACIS)	CMS	1			
70	water bath, general purpose (lab)	CMS	1		1	

2

AMA Specialty Society Recommendation

	A	B	C	D	E	F	G	H
2			CPT Code: 88365		CPT Code: 88367		CPT Code: 88368	
3		CMS Code	Code Descriptor: In situ hybridization (eg, FISH), each probe *		Code Descriptor: Morphometric analysis, In situ hybridization, (quantitative or semi-quantitative) each probe; using computer-assisted technology #		Code Descriptor: Morphometric analysis, in situ hybridization, (quantitative or semi-quantitative) each probe; manual	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD		XXX		XXX		XXX	
6	TOTAL CLINICAL LABOR TIME		98.5 58.5	0.0	86 50.5	0.0	103.5-58.5	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037B	88-53.5	0.0	74- 44.5	0.0	88-53.5	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037B	0.0	0.0	0.0	0.0	0.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037B	40.5 5	0.0	45- 6	0.0	45.5-5	0.0
10	<b>PRE-SERVICE</b>							
11	Start: When containers/requisitions prepared for physician							
12	Retrieve and accession specimen	L037B	2.5		2.5		2.5	
13	Gather all the relevant slides, prior report, and history on the patient for the pathologist to review to choose the region of interest on the slide	L037B	5		5		5	
14	Prepare reagents and equipment. Re-cut paraffin blocks and bake slides. Deparaffinize, treat with HCL, wash. Treat with enzyme, wash and rehydrate. Apply DNA probe mixture to positive, negative control and patient's slide. Allow to hybridize in chamber for 16 hours. Apply DAPI, coverslip, and label. Deliver slides to pathologist.	L037B	75.5 45		55.5- 33		75.5 45	
15	Load slides on Auto Vysis Scanner, and enter slide IDs. Verify controls using fluorescent microscope. After pathologist has verified fields of interest, select the fields to be scanned.	L037B			8- 4			
16	Verify controls using fluorescent microscope. Deliver slides to pathologist.	L037B	5- 1				5- 1	
17	End: When specimen is ready for examination by pathologist.							
18	<b>SERVICE PERIOD</b>							
19	Start: When specimen is ready for examination by pathologist							
20	Coordinate care							
21	End: When specimen examination by pathologist is complete							
22	<b>POST-SERVICE Period</b>							
23	Start: When specimen examination by pathologist is complete							
24	Prepare, pack and transport specimens and records for in-house storage and external storage	L037B	5-2		5-2		7-2	
25	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L037B	2.5-1		7-1		5.5-1	
26	Clean room/equipment following procedure (including any equipment maintenance that must be done after the procedure)							
27	Manage any relevant utilization review/quality assurance activities and regulatory compliance documentation	L037B	3-2		3-2		3-2	
28	Submit/receive material for consultation (where applicable)							
29	Other Activity (please specify)							
30	End: When specimen, chemical waste and record handling is complete							
31	Other Activity (please specify)							

AMA Specialty Society Recommendation

	A	B	C	D	E	F	G	H
2			CPT Code: 88365		CPT Code: 88367		CPT Code: 88368	
3		CMS Code	Code Descriptor: In situ hybridization (eg, FISH); each probe *		Code Descriptor: Morphometric analysis, In situ hybridization, (quantitative or semi-quantitative) each probe; using computer-assisted technology #		Code Descriptor: Morphometric analysis, In situ hybridization, (quantitative or semi-quantitative) each probe; manual *	
4	LOCATION		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
32	<b>MEDICAL SUPPLIES</b>							
33	Filtration unit, disposable, 0.45u pore, 1000 ul		0.4		0.4		0.4	
34	Filtration unit, disposable, 0.45u pore, 250 ul		0.4		0.4		0.4	
35	Organosilane Coated Slides		4 0.25		0.125		4 0.25	
36	Gloves, non-sterile, nitrile	SB023	4 0.25		0.125		4 0.25	
37	Eye shield, splash protection	SM016	4 0.25		0.125		4 0.25	
38	Gown, staff, impervious	SB027	4 0.25		0.125		4 0.25	
39	Mask, surgical	SB033	4 0.25		0.125		4 0.25	
40	Hemo-De (for deparaffinization)		75 ml- 37.5		18.8 ml		75 ml- 37.5	
41	100 % EtOH (for deparaffinization)		50 ml-25		12.5		50 ml-25	
42	FISH Paraffin Pretreatment kit (includes protease)		4.5-1		0.75		4.5-1	
43	0.2 N HCl		25 ml-12.5		6.25 ml		25 ml-12.5	
44	Neutral Buffered Formalin	SL070	4 ml .5		0.25 ml		4 ml .5	
45	Phosphate Buffered Saline (PBS)	SL106	25 ml-12.5		6.25 ml		25 ml-12.5	
46	BCR/ABL DNA probe applications *		1.5-2		na		na	
47	Her 2 Neu Probe applications **		na		0.75 4.5		1.5 2	
48	BCR/ABL Positive /Negative Control Slides		0.5		na		na	
49	Her 2 Neu positive control slide				0.125		0.5 0.25	
50	Her 2 Neu negative control slide				0.125		0.5 0.25	
51	Formamide		25 ml-12.5		6.25 ml		25 ml-12.5	
52	70 % Ethanol (EtOH)		25 ml-12.5		6.25 ml		25 ml-12.5	
53	85 % EtOH		25 ml-12.5		6.25 ml		25 ml-12.5	
54	100 % EtOH		25 ml-12.5		6.25 ml		25 ml-12.5	
55	Glass Cover slips	SL030	4.5-1		0.75		4.5-1	
56	Sterile pipette Tips		4.5-1		0.75		4.5-1	
57	Rubber Cement		.75 ml-0.4		0.3 ml		.75 ml-0.4	
58	DAPI II counterstain/mounting media		15 microliters		7.5 microliters		15 microliters	
59	5 mL Syringe	SC057	0.5 0.25		0.125		0.5 0.25	
60	1 N NaOH		0.5 0.25		0.125 ml		0.5 0.25	
61	Slide label	SL085	4.5 0.75		0.75		4.5 0.75	
62	Immersion Oil	SL080	0.2 ml- 0.1		0.05 ml		0.2 ml- 0.1	
63	Photo Inkjet Paper		4		4		4	
64	Plain Inkjet Paper		4		4		4	
65	Printer Ink Cartridge (Black)		4		4		4	
66	Printer Ink Cartridge (Color)		4		4		4	
67	blade, microtome	SF004	0.5 0.25		0.125		0.5 0.25	
68	<b>Equipment</b>							
69	Fluorescence microscope with filters		1		1		1	
70	Hybridization Chamber		1		1		1	
71	PH Meter	E13644	1		1		1	
72	Slide Warmer		1		1		1	
73	Benchtop Microfuge		1		1		1	
74	Isotemp Oven		1		1		1	
75	Microtome	E13618	1		1		1	
76	microscope, compound	E13601	1		1		1	
77	Vysis AutoVysion Scanner		4-NA		1		4-NA	
78	Waterbath, heat circulating for 80°C and 37°C treatments		2		2		2	
79	* A run of 2 patients and 2 controls costed for a single probe							
80	# A run of 4 patients and 2 controls costed for a single probe.							